DOCUMENT RESUME

ED 431 982 CG 029 334

TITLE	Mental Health and School-Based Health Centers. Guidebook.
INSTITUTION	California Univ., Los Angeles. Center for Mental Health in Schools.
SPONS AGENCY	Health Resources and Services Administration (DHHS/PHS), Washington, DC. Maternal and Child Health Bureau.
PUB DATE	1997-09-00
NOTE	497p.
AVAILABLE FROM	School Mental Health Project, Center for Mental Health in Schools, Dept. of Psychology, UCLA, 405 Hilgard Ave., Los Angeles, CA 90095-1563; Tel: 310-825-3634; Fax: 310-206-8716; E-mail: smhp@ucla.edu; Web site: http://smhp.psych.ucla.edu (minimal fee to cover copying, postage and handling).
PUB TYPE	Guides - Classroom - Learner (051)
EDRS PRICE	MF02/PC20 Plus Postage.
DESCRIPTORS	Cooperation; Crisis Intervention; Cultural Differences; Dialogs (Language); Due Process; Elementary Secondary Education; Financial Support; *Mental Health; *Mental Health Clinics; Racial Differences; Referral; Resources; School Community Programs; *School Counseling; *School Health Services; School Psychologists; Student Motivation; Student Needs
IDENTIFIERS	Case Management; Triage

ABSTRACT

This guidebook consists of three parts. The first part is an introductory overview focusing on where mental health facets of school-based health centers (SBHC) fit into the work of schools. The second part is made up of three modules, each containing a set of units and resource aids focusing on day-by-day SBHC operational considerations and concerns related to the following: approaching the problem of limited resources not only as one of fundraising but as a major reason for integrating center activity with school and community efforts; specific facets of working with students who come to the center; and approaching evaluation as a process of getting credit for work done by school counselors. The third part is a coda that highlights ways to and benefits of integrating the resources available for addressing barriers to student learning into a comprehensive, integrated approach. A glossary of key terms, acronyms, and laws is provided. (MKA)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED 431 982

Mental Health in Schools Center
Training and Technical Assistance

Guidebook:

MENTAL HEALTH
AND
SCHOOL-BASED HEALTH CENTERS

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☐ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
● Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
P NELSON
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

The Center for Mental Health in Schools operates under the auspices of the School Mental Health Project,
Dept. of Psychology, UCLA, Los Angeles, CA 90095-1563 -- (310) 825-3634.
Co-directors are Howard Adelman & Linda Taylor.

Support comes in part from the Dept. of Health and Human Services,
Public Health Service, Health Resources and Services Administration,
Maternal and Child Health Bureau, Office of Adolescent Health.

U.S. Department of Health & Human Services
Public Health Service
HRSA
Health Resources & Services Administration
Maternal & Child Health Bureau
Office of Adolescent Health

CG029334

BEST COPY AVAILABLE

Mental Health in Schools
Center
Training and Technical Assistance

Guidebook:

MENTAL HEALTH
AND
SCHOOL-BASED HEALTH CENTERS

Introductory Perspective: The Mental Health Facets of School-Based Health Centers

Module I: Addressing the Problem of Limited Center Resources

Module II: Working with Students Who Come to the Center

Module III: Program Reporting: Getting Credit for All You Do

Coda: Toward a Comprehensive, Integrated Approach to Addressing Barriers to Student Learning

The Center for Mental Health in Schools operates under the auspices of the School Mental Health Project,
Dept. of Psychology, UCLA, Los Angeles, CA 90095-1563 -- (310) 825-3634.
Co-directors are Howard Adelman & Linda Taylor.

Support comes in part from the Dept. of Health and Human Services,
Public Health Service, Health Resources and Services Administration,
Maternal and Child Health Bureau, Office of Adolescent Health.

U.S. Department of Health & Human Services
Public Health Service
HRSA
Health Resources & Services Administration
Maternal & Child Health Bureau
Office of Adolescent Health

Schools of the 21st century will call upon us all to play new and expanding roles. Those working in schools have both the opportunity and the responsibility to lead the way into the new century. To do so, they must become major participants in the movements to reform and restructure schools, and they must help shape initiatives that are attempting to link community resources to schools.

Working closely with others concerned about psychosocial problems and healthy development, school-based health centers can help broaden reform and restructuring in ways that truly address the barriers to student learning and enhance healthy development. In the process, they will continue to redefine their roles and functions and expand the ways in which schools contribute to the well-being of young people and the society. In schools, a focus on physical and mental health must be part of a comprehensive, integrated approach to addressing barriers to student learning and enhancing healthy development. To work effectively in such a context, school-based health centers must play a multifaceted and catalytic role and must focus both on helping individuals deal with personal problems and on helping systems (classrooms, schools, families) function more effectively.

BEST COPY AVAILABLE

GUIDEBOOK:

MENTAL HEALTH AND SCHOOL-BASED HEALTH CENTERS

Complete Contents

Page

Preface i

To Users of the Guidebook iii

Introductory Perspective: The Mental Health Facets of School-Based Health Centers

- Why Mental Health in Schools? 1
- What Do Schools Offer Related to Mental Health? 6
- Where Does a School-Based Health Center Fit In? 7
- A Multifaceted and Catalytic Role for School-Based Health Centers 10

A Few Related References 20

Module 1: Addressing the Problem of Limited Center Resources

Unit IA. Meeting the Challenge of Limited Financial Resources

- Finding the Funds IA-1
- Optimizing the Use of the Center's Mental Health Professional IA-7

  >Proposed Tasks for 10 Hours IA-7
  >Added Tasks for a 20 hour Week IA-9
  >30 or More Hours IA-9
  >Starting From Zero IA-10

Resource Aids IA-11

Unit IB. Integrated Activity to Maximize Resource Use and Effectiveness

- Working Together with School and Community IB-1
  - >Phases of Collaboration IB-2
    - Integrating with the Center IB-2
    - Integration of Health Center into the School IB-3
    - Outreach and Networking Outside the School IB-3
  - >Phases of Health Center Integration, Outreach, and Networking IB-4
  - >Working Together with Others to Enhance Programs and Resources IB-5
  - >It's Not Just About Collaboration -- It's About Being Effective IB-5
    - A team to manage care IB-10
    - A team to manage resources IB-12
  - >Fully Integrating with School and Community Resources IB-15
- Overcoming Barriers to Working Together IB-17
  - >Differences as a Problem IB-17
  - >Differences as a Barrier IB-18
  - >Overcoming Barriers Related to Differences IB-20
  - >Building Rapport and Connection IB-21
- One Other Observation IB-24
- Coda: Enhancing Available Resources IB-25

Resource Aids IB-27

A Few Related References IB-62

Module II: Working with Students Who Come to the Center

Overview II-1

Unit IIA. Consent, Due Process, and Confidentiality IIA-1

- Consent and Due Process IIA-1
- Confidentiality and Privacy IIA-5

Resource Aids IIA-10

Unit IIB. Problem Identification, Prereferral Intervention, and Consultation with School Staff

- Initial Problem Identification IIB-1
- Prereferral Interventions IIB-2
- Staff Consultation IIB-3
    >Mental Health Consultation in Schools IIB-3
    >Collaborative Consultation IIB-3
    >Barriers to Collaboration IIB-6
    >Toward School-Based Consultation Teams IIB-7
    > Offering Consultation and Responding to Requests IIB-8
    >Concluding Comments IIB-8

Resource Aids IIB-10
A Few Related References IIB-26

Unit IIC. Screening/Assessment

- More than Identifying a Problem IIC-1
- A Few Procedural Guidelines and Specific Topics to Explore IIC-1

Resource Aids IIC-7
A Few Related References IIC-21

Unit IID. Client Consultation and Referral

- More than Giving a Name and Address IID-1
- The Referral Process: Some Guidelines and Steps IID-2
- Providing Information about Programs and Services IID-6
- Developing Ways to Facilitate Access to Resources IID-7
    >Highlighting the Most Accessible Referral Resources IID-7
    >Referral Resource Files IID-8
    >Support and Direction for Follow-Through IID-9
    >Personal Contact with Referral Resources IID-10
    >Enhancing On-Campus Services IID-11
- Following-Up on Referrals (including consumer feedback) IID-14

Resource Aids IID-15

Unit IIE. Responding to Students' Ongoing Psychosocial and Mental Health Needs

- Psychosocial Guidance and Support IIE-1
- Psychosocial Counseling IIE-2
- Prevention/Mental Health Education IIE-12

Resource Aids IIE-16

Cited References IIE-23

Unit IIF. Responding to Crises at a School

- School-Based Crisis Intervention: Overview IIF-2
  - >Who Should Be Responsible? IIF-4
  - >Planning for Crises IIF-5
  - >A School-Based Crisis Team IIF-10
  - >Crisis Aftermath Subteams IIF-15
  - >Maintaining Crisis Response Capability and School Awareness IIF-17
- Psychological First Aid IIF-18
- Addressing Specific Areas of Concern Related to Crises IIF-22

Resource Aids IIF-23

A Few Related References IIF-48

Unit IIG. Management of Care & Follow-up Evaluation (Case Management)

- Initial Monitoring of Care IIG-2
- Ongoing Monitoring/Management of Care IIG-3

Resource Aids IIG-7

A Few References on the Basics of Helping and Counseling IIG-18

Appendix II-1: Connecting the Student with the Right Help

Appendix II-2: About the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)

Appendix II-3: Organizing and Training a School-Based Crisis Team

Appendix II-4: Addressing Specific Areas of Concern Related to Crises

Module III. Program Reporting: Getting Credit for All You Do

Unit IIIA. Quality Improvement, Evaluating Outcomes, and Getting Credit for All You Do

- Evaluation that Fosters Quality Improvement IIIA-1
- Evaluation Focused on Results IIIA-2
  - >Student Outcomes IIIA-3
    - Outcomes Reflecting Enhanced Receptivity to Instruction IIIA-3
    - Outcomes Related to Prevention and Correction of Emotional, Behavioral, Learning, and Health Problems IIIA-5
  - >Intended Impact on Families and Communities IIIA-8
  - >Intended Impact on Programs and Systems IIIA-8

Resource Aids IIIA-9

A Few Related References IIIA-14

Unit IIIA. Evaluating in Stages

- Stage I -- Initial Mental Health Program Development, Implementation, and Evaluation IIIB-3
- Stage II -- Integration with Relevant School Psychosocial Programs & Expansion of Programs, Services, and Evaluation Focus IIIB-5
- Stage III --Outreach to School District/Community Psychosocial Programs and Further Expansion of Programs, Services, and Evaluation Focus IIIB-7
  - >Problem Screening and Analysis IIIB-8
  - >Problem Resolution IIIB-9
- Stages IV-VI IIIB-10
  - >IV -- Institutionalization of programs and services IIIB-10
  - >V -- Short-term follow-up evaluation IIIB-10
  - >VI -- Long-term follow-up evaluation IIIB-11

Resource Aids IIIB-12

Appendix III-1: Quality Assurance and Documenting Program Effectiveness (Excerpts from: Critical Issues Planning Conducted by the Center for School Mental Health Assistance)

Coda: Comprehensive Approaches and Mental Health in Schools

- Comprehensiveness and Mental Health in Schools Coda 1
- Comprehensive School-Based Centers Coda 1
- Comprehensive School Health Coda 1
- Toward a Comprehensive, Integrated Approach Coda 2

GLOSSARY

EXHIBITS

Page

Introduction

1. Barriers to Learning 2
2. A Graphic Representation of the Problem of Barriers to Learning 3
3. From Primary Prevention to Treatment of Serious Problems: A Continuum of Community-School Programs 5
4. Types of Interveners and Functions 8
5. Example of the Range of Interveners and Interventions Needed 15

Module I

Unit IA

6. Funding Sources for School Based Health Programs IA-2

Unit IB

7. Some General Guidelines for Establishing School Site Collaborative Teams IB-7
8. Planning and Facilitating Effective Meetings IB-8
9. Accounting for Cultural, Racial, and Other Significant Individual and Group Differences IB-22

Module II

Overview

10. Direct Interventions II-6
11. Intervention Flow Chart II-7
12. Matters for a School to Consider in Developing its Systems for Problem Identification, Triage, Referral, and Case Management II-8
13. Steps in Meeting Students' Needs II-9

Unit IIA

14. Some Due Process Safeguards IIA-3

Unit IIB

15. A Guide for Teachers and Other School Staff Regarding the Prereferral Process IIB-2
16. Building Rapport and Connection IIB-4

Unit IIC

17. A Basic Interview Format IIC-2
18. Outline of Specific Areas and Topics that Might Be Explored to Better Understand the Nature and Scope of Problems IIC-4

Unit IID

19. Referral Intervention Guidelines and Steps IID-3

Unit IIE

20. A Few Thoughts About Engaging Students in a Productive Dialogue IIE-4
21. Some Points About Counseling and Student Motivation IIE-6

Unit IIF

22. Scope of Crisis Events and Intervention Phases IIF-8
23. Major Facets of Crises Response IIF-9
24. A Few General Principles Related to Responding to Crises IIF-19

Module III

Unit IIIB

25. Six Stages in the Development and Evaluation of the Mental Health Focus of School-Based Health Centers IIIB-2
26. Stage I -- Mental Health Program Development & Initial Implementation IIIB-4
27. Stage II -- Integration with Relevant School Psychosocial Programs & Expansion of Programs, Services, and Evaluation Focus IIIB-6

RESOURCE AIDS

Page

Module I

Unit IA

IA-1. Examples of Federal Resources IA-12

Unit IB

IB-1. Survey Instruments to Aid in Mapping and Analyzing Existing School-Based/Linked Psychosocial and Mental Health Systems, Programs, and Services IB-29
IB-2 Developing a Resource Coordinating Team IB-58
IB-3 Developing a Complex (Multisite) Resource Coordinating Council IB-60

Module II

Unit IIA

IIA-1 SBHC Informed Consent Form IIA-11
IIA-2 Consent to Exchange Confidential Information IIA-14

Unit IIB

IIB-1 Helping Students with Psychosocial Problems Seek Help IIB-12
IIB-2 Triage Review Request Form (Request for Assistance in Addressing Concerns About a Student/Family) IIB-13
IIB-3 Being Alert to Indicators of Psychosocial and Mental Health Problems IIB-14
IIB-4 Being Specifically Alert to Substance Abuse Indicators IIB-16
IIB-5 Exploring the Problems with the Student and Family (Guidelines to Give Teachers) IIB-18
IIB-6 Prereferral Interventions: Some Things to Try (Guidelines to Give Teachers) IIB-19
IIB-7 Letter to Teachers Regarding Availability of Consultation IIB-20
IIB-8 Reminder and Survey Related to Identifying Consultation Needs IIB-21
IIB-9 Example of Inservice Presentation to Enhance Staff Skills for Talking and Listening to Students IIB22
IIB-10 Outline of Key Steps and Tasks in Problem Solving Intervention IIB-25

Unit IIC

IIC-1 Health Center Student Registration Form and Screening Questionnaire IIC-9
IIC-2 Student View of Problem -- Survey Questionnaire Initial Interview Form IIC-13
IIC-3 Substance Abuse Checklist IIC-19

Unit IID

IID-1 Description of Referral Resource Files IID-17

IID-2 Examples of Resource Information Handouts IID-20

IID-3 Example of One School District's Referral Policy IID-23

IID-4 Referral Decisions -- Summary Form IID-25

IID-5 Guidelines for Acknowledging Status of Referral IID-26

IID-6 Referral Follow-Through Forms and School Record Form of Response to Request for Assistance IID-27

IID-7 Form Used to Aid Follow-up on Referral Follow-Through IID-30

Unit IIE

IIE-1 SBHC Student Visit Form (Chart Record) -- Mental Health and and Psychosocial Concerns IIE-19

IIE-2 Where to Get Resource Materials to Address Barriers to Learning IIE-22

Unit IIF

IIF-1 District Policy Considerations IIF-25

IIF-2 Crisis Response Checklist IIF-26

IIF-3 Some Key Considerations in Establishing a System for School-Based Crisis Response IIF-30

IIF-4 Informing the Students and Staff IIF-34

IIF-5 A Few Indicators of Reactions to Trauma IIF-37

IIF-6 A Crisis Screening Interview IIF-39

IIF-7 Aftermath Classroom Activities IIF-42

Unit IIG

IIG-1 Follow-Up Rating Form -- Service Status IIG-8

IIG-2 Management of Care Review Form IIG-10

Module III

Unit IIIA

IIIA-1 Intervention Impact on Students IIIA-10

IIIA-2 Intervention Impact on Families and Communities IIA-11

IIIA-3 Intervention Impact on Programs and Systems IIIA-13

Unit IIIB

IIIB-1 Daily Log Record IIIB-14

IIIB-2 Consultation Encounter Form IIIB-16

IIIB-3 Consultation Follow-up Data and Feedback Form IIIB-17

IIIB-4 Initial Student Data a SBHC Can Report IIIB-18

IIIB-5 SBHC Student Visit Form (Chart Record) -- Mental Health and and Psychosocial Concerns IIIB-30

IIIB-6 Gathering Data on Clinic Use and Nonuse and Needs Assessment IIIB-35

IIIB-7 A Flowchart of a 52 Week Evaluation Process IIIB-36

RELATED RESOURCE AID PACKETS AVAILABLE FROM THE UCLA CENTER FOR MENTAL HEALTH IN SCHOOLS

The Center develops introductory, resource, and technical aid packets on key topics. The *Introductory Packets* consist of overview discussions, descriptions of model programs (where appropriate), references to publications, access information to other relevant centers, agencies, organizations, advocacy groups, and Internet links, and a list of consultation cadre members ready to share expertise. The *Resource Aid Packets* are designed to complement the Introductory Packets. They are a form of *tool kit* for fairly circumscribed areas of practice. They contain materials to guide and assist with staff training and student/family interventions -- including overviews, outlines, checklists, instruments, and other resources that can be reproduced and used as information handouts and aids for training and practice. *Technical Aid Packets* are designed to provide basic understanding of specific practices and tools. The Center also prepares continuing education modules and guidebooks such as this one.

Materials from some of the Center's diverse Clearinghouse resources have been included in this guidebook.

Below is a brief listing of some other relevant packets and related materials you may want to request as supplementary resources. The materials are listed related to our three major Clearinghouse categories.

I. System Concerns

Working Together: From School-Based Collaborative Teams to School-Community-Higher Education Connections (Introductory Packet)

Discusses processes and problems related to working together at school sites and in school-based centers. Outlines models of collaborative school-based teams and interprofessional education.

II. Program/Process Concerns

Violence Prevention and Safe Schools (Introductory Packet)

Outlines selected violence prevention curricula and school programs and school-community partnerships for safe schools. Emphasizes both policy and practice.

Least Intervention Needed: Toward Appropriate Inclusion of Students with Special Needs (Introductory Packet)

Highlights the principle of *least intervention needed* and its relationship to the concept of *least restrictive environment*. From this perspective, approaches for including students with disabilities in regular programs are described.

Parent and Home Involvement in Schools (Introductory Packet)

Provides an overview of how home involvement is conceptualized and outlines current models and basic resources. Issues of special interest to under-served families are addressed.

Confidentiality and Informed Consent (Introductory Packet)

Focuses on issues related to confidentiality and consent of minors in human services and interagency collaborations. Also includes sample consent forms.

Understanding and Minimizing Staff Burnout (Introductory Packet)

Addresses various sources and issues of burnout and compassion fatigue among school staff and mental health professionals. Also identifies ways to reduce environmental stressors, increase personal capability, and enhance social support to prevent burnout.

Assessing to Address Barriers to Learning (Introductory Packet)

Discusses basic principles, concepts, issues, and concerns related to assessment of various barriers to student learning. It also includes resource aids on procedures and instruments to measure psychosocial, as well as environmental barriers to learning.

Cultural Concerns in Addressing Barriers to Learning (Introductory Packet)

Highlights concepts, issues and implications of multiculturalism/cultural competence in the delivery of educational and mental health services, as well as for staff development and system change. This packet also includes resource aids on how to better address cultural and racial diversity in serving children and adolescents.

Screening/Assessing Students: Indicators and Tools (Resource Aid Packet)

Designed to provide some resources relevant to screening students experiencing problems. In particular, this packet includes a perspective for understanding the screening process and aids for initial problem identification and screening of several major psychosocial problems.

Students and Psychotropic Medication: The School's Role (Resource Aid Packet)

Underscores the need to work with prescribers in ways that safeguard the student and the school. Contains aids related to safeguards and for providing the student, family, and staff with appropriate information on the effects and monitoring of various psychopharmacological drugs used to treat child and adolescent psycho-behavioral problems.

School-Based Mutual Support Groups (for Parents, Staff, Older Students)
(Technical Aid Packet)

This is a technical guide for establishing self-led support groups. It provides a step-by-step framework for establishing and maintaining such groups and includes resource aids such as announcement flyers and letters.

III. *Psychosocial Problems*

Dropout Prevention (Introductory Packet)

Highlights intervention recommendations and model programs, as well as discussing the motivational underpinnings of the problem.

Learning Problems and Learning Disabilities (Introductory Packet)

Identifies learning disabilities as one highly circumscribed group of learning problems, and outlines approaches to address the full range of problems.

Teen Pregnancy Prevention and Support (Introductory Packet)

Covers model programs and resources and offers an overview framework for devising policy and practice.

Substance Abuse **(Resource Aid Packet)**

Offers some guides to provide schools with basic information on widely abused drugs and indicators of substance abuse. Includes some assessment tools and reference to prevention resources.

Clearinghouse Catalogue **(Resource Aid Packet)**

Our Clearinghouse contains a variety of resources relevant to the topic of mental health in schools. This annotated catalogue classifies these materials, protocols, aids, program descriptions, reports, abstracts of articles, information on other centers, etc. under three main categories: policy and system concerns, program and process concerns, and specific psychosocial problems. (Updated regularly)

Consultation Cadre **Catalogue (Resource Aid Packet)**

Provides information for accessing a large network of colleagues with relevant experiences related to addressing barriers to student learning and mental health in schools. These individuals have agreed to share their expertise without charging a fee. The catalogue includes professionals indicating expertise related to major system and policy concerns, a variety of program and process issues, and almost every type of psychosocial problem. (Updated regularly)

Catalogue *of Internet Sites Relevant to Mental Health in Schools*
(Resource Aid Packet)

Contains a compilation of internet resources and links related to addressing barriers to student learning and mental health in schools. (Updated regularly)

Organizations with Resources Relevant to Addressing Barriers to Learning: **A Catalogue *of Clearinghouses, Technical Assistance Centers, and Other Agencies*** **(Resource Aid Packet)**

Categorizes and provides contact information on organizations focusing on children's mental health, education and schools, school-based and school-linked centers, and general concerns related to youth and other health related matters. (Updated regularly)

Where to Get Resource Materials to Address Barriers to Learning
(Resource Aid Packet)

Offers school staff and parents a listing of centers, organizations, groups, and publishers that provide resource materials such as publications, brochures, fact sheets, audiovisual & multimedia tools on different mental health problems and issues in school settings.

PREFACE

MENTAL HEALTH AND SCHOOL-BASED HEALTH CENTERS

Nothing less than the futures of children is at stake.
Nicholas Hobbs

Over the last decade, the staff of the School Mental Health Project at UCLA has addressed concerns relevant to school-based and linked mental health intervention. For a couple of years, the Robert Wood Johnson Foundation provided us with some support related to development of the mental health facets of school-based health centers. In October 1995, the U.S. Department of Health and Human Services, Maternal and Child Health Bureau, Office of Adolescent Health provided support to help establish two national centers focused on mental health in schools: our Center at UCLA and another at the University of Maryland at Baltimore. Our center's agenda encompasses the aim of ensuring that mental health in schools is part of a comprehensive, integrated approach to addressing the many mental health and psychosocial concerns with which students, schools, families, and communities increasingly are confronted.

Why a *comprehensive* approach? The need for comprehensive approaches stems from awareness of the role school, home, and community life play in creating and correcting young peoples' problems, especially those who are under-served and hard-to-reach. From such a perspective, it is clear that a focus on mental health in schools encompasses activity to both help individuals and change systems. More specifically, a comprehensive approach encompasses (a) prevention and prereferral interventions for mild problems, (b) high visibility programs for high-frequency psychosocial problems, and (c) strategies to assist with severe and pervasive mental health problems.

Much of our Center's work is designed to enhance policy and practice for addressing barriers to student learning and promoting healthy development, as well as to ensure there are relevant resources to aid practitioners, researchers, and policy makers. Among the resources we offer are a clearinghouse, technical assistance, print and electronic newsletter, a website, specially designed packets on key topics, continuing education modules, and guidebooks.

This guidebook on *Mental Health and School-Based Health Centers* consists of

(a) an introductory overview focused on where the mental health facets of school-based health centers (SBHC) fit into the work of schools,

(b) three modules, each containing a set of units and resource aids focused on day-by-day SBHC operational considerations and concerns related to

- approaching the problem of limited resources not only as a one of fund raising, but as a major reason for integrating center activity with school and community efforts
- specific facets of working with students who come to the center
- approaching evaluation as a process of getting credit for all you do

(c) a coda that highlights ways to and benefits of weaving together all resources for addressing barriers to student learning into a comprehensive, integrated approach.

SBHCs, like people, are developing organisms. A SBHC's activity should reflect its level of development. Initially, staff feel pressure to do everything at once -- which is a certain recipe for burnout. The procedures described in the various units take time to develop and implement. Thus, in some instances, we differentiate between initial and subsequent developmental phases. For a unit to be most useful, staff members should review it periodically to evaluate which aspects they have incorporated and which they are now ready to add.

While the Center's co-directors assume full responsibility for the guidebook's contents, every facet of our Center's activity reflects the direct and indirect contributions of too many people to be acknowledged here. The Center staff does want to once again thank each of you, and we hope you feel a sense of satisfaction in seeing your contributions in products such as this guidebook.

Finally, we hope the material contained in all our documents represent a timely and progressive approach. At the same time, the content, like the field itself, is in a state of continuous evolution. Thus, we are extremely interested in receiving your feedback. Please send your comments to: Howard S. Adelman and Linda Taylor, Co-Directors, Center for Mental Health in Schools, UCLA Department of Psychology, Los Angeles, CA 90095-1563.

To Users of this Guidebook:

The material in the guidebook is designed as an evolving set of modules. Each module consists of several units conceived to stand alone. Although the material could be read straight through like a text, it is meant to be used as a resource work. You might approach the content as you would use an Internet website (i.e., exploring specific topics of immediate interest and then going over the rest in any order that feels comfortable). The introduction is meant to start you off with a big picture framework for understanding the context of School Based Health Centers and mental health in schools. The Coda on *Comprehensive Approaches and Mental Health in Schools* provides an additional perspective on emerging trends.

A good way to start is simply to browse through the Table of Contents and any units, exhibits, or resource aids that you think may be of use to you. We recommend reading the introduction as soon as you have the time. Then, do an in depth review of a unit that focuses on the matter that is of greatest concern to you at this time.

MENTAL HEALTH AND SCHOOL-BASED HEALTH CENTERS

Introductory Perspective:

The Mental Health Facets of School-Based Health Centers

> *What the best and wisest parent wants for his (her) own child that must the community want for all of its children. Any other idea . . . is narrow and unlovely.*
>
> John Dewey

Data on diagnosable mental disorders (based on community samples) suggest that from 12% to 22% of all children suffer from mental, emotional or behavioral disorders, and relatively few receive mental health services. The picture is even bleaker when expanded beyond the limited perspective of *diagnosable* mental disorders to include all young people experiencing psychosocial problems and who Joy Dryfoos defines as "at risk of not maturing into responsible adults." The number "at risk" in many schools serving low-income populations has climbed over the 50% mark. Harold Hodgkinson , director of the Center for Demographic Policy, estimates across the nation 40% of students are in "very bad educational shape" and "at risk of failing to fulfill their physical and mental promise." Because so many live in inner cities and impoverished rural areas and are recently arrived immigrants, he attributes their school problems mainly to conditions they bring with them when they enter kindergarten. These are conditions associated with poverty, difficult and extremely diverse family circumstance, lack of English language skills, violent neighborhoods, physical and emotional problems, and lack of health care. One impact is that at least 12% fail to complete high school, which leads to extensive consequences for them, their families, and society.

Why Mental Health in Schools?
What Do Schools Offer Related to Mental Health?
Where Does a School-Based Health Center Fit In?
A Multifaceted and Catalytic Role for School-Based Health Centers

BEST COPY AVAILABLE

Why Mental Health in Schools?

Advocates for more mental health programs and services in schools note the following:

- All available evidence suggests that many young people are experiencing mental health and psychosocial problems.

- Most of these individuals go unidentified by helping professions.

- Most who are identified go unserved.

- Even when identified and referred to treatment programs for help, most students do not connect with the referral.

- And, in many locales, referral is not even feasible because appropriate services are not available.

For the most part, however, such reasoning has not carried the day.

Mental Health and the Mission of Schools

What has led schools to offer some mental health-related programs are the legal mandates requiring certain services for students diagnosed with special education needs. Another factor is recognition by school policy makers and practitioners that social, emotional, and physical health problems and other major barriers to learning must be addressed if schools are to function satisfactorily and students are to learn and perform effectively.

It is clear, however, that mental and physical health programs are not a primary item on a school's agenda. This is not surprising. After all, schools are not in the health business. Their mandate is to educate.

Activities not directly related to instruction often are seen only as taking resources away from a school's primary mission. Indeed, it is commonplace to hear teachers and school administrators comment: "We have enough to do here without taking on the role of providing health and social services!"

Thus, if the focus on mental health in schools across the country is to expand, the entire enterprise must be integrated into schools in ways that make it an integral and essential part of enabling the school to meet its primary mission. In this respect, one message that must be conveyed is that too many students are not benefitting from instruction (including new approaches advocated by reformers) because they are encountering barriers to learning (see Exhibits 1 and 2).

A complementary message that must be conveyed is that the mission of educating all students requires a comprehensive set of interventions that address barriers to learning in an integrated way. What is needed is a full continuum of programs and services.

Exhibit 1: Barriers to Learning

Outlined below are some common barriers usually identified as interfering with learning/ parenting/ teaching. Think about and perhaps discuss with your colleagues which of these you see everyday and what others you would add to the list.

Deficiencies in basic living resources and opportunities for development

- dearth of food in the home
- inadequate clothing
- substandard housing (incl. being homeless)
- lack of transportation
- income at or below the poverty level (e.g., due to unemployment or welfare status)
- lack of after-school supervision for child
- lack of youth recreation and enrichment
- immigration-related concerns (e.g., limited English proficiency, legal status)
- lack of home involvement in schooling
- lack of peer support
- lack of community involvement
- lack of school support services
- lack of social services
- lack of physical, dental, and mental health services

Psychosocial problems

- physical health problems
- school adjustment problems (incl. school avoidance, truancy, pregnancy, and dropouts)
- relationship difficulties (incl. dysfunctional family situations, insensitivity to others, social withdrawal, peers who are negative influences)
- deficiencies in necessary skills (e.g., reading problems, language difficulties, poor coordination, social skill deficits)
- abuse by others (physical and sexual)
- substance abuse
- Overreliance on psychological defense mechanisms (e.g., denial, distortion, projection, displacement)
- eating problems
- delinquency (incl. gang-related problems and community violence)
- psychosocial concerns stemming from sexual activity (e.g., prevention of and reactions to pregnancy or STDs)
- psychopathology/disabilities/disorders

General stressors and underlying psychological problems associated with

- external stressors (objective and perceived) and deficits in support systems
- competence deficits (low self-efficacy/self-esteem, skill deficits)
- threats to self-determination/autonomy/control
- feeling unrelated to others or perceiving threats to valued relationships
- emotional upsets, personality disorders, mood disorders and other psychopathology

Crises and emergencies

- personal/familial (incl. home violence)
- subgroup (e.g., death of a classmate or close colleague)
- school-wide (e.g., earthquake, floods, shooting on campus)

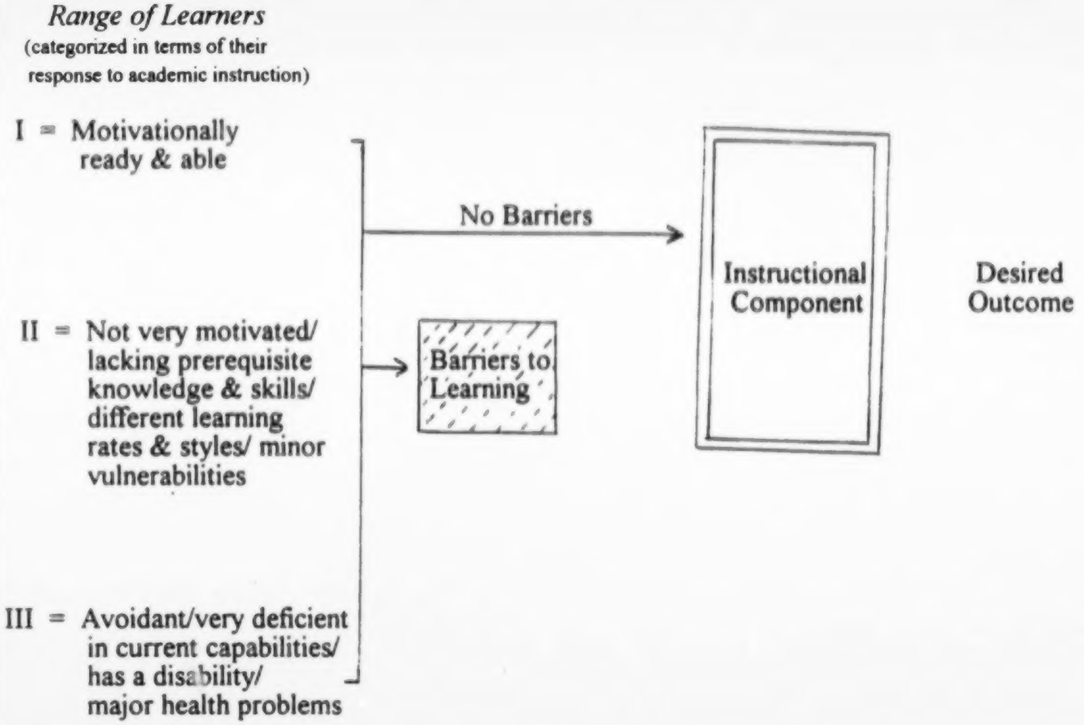
Difficult transitions

- associated with stages of schooling (e.g., entry, leaving)
- associated with stages of life (e.g., puberty, gender identity, job and career concerns)
- associated with changes in life circumstances (e.g., moving, death in the family)

Note: The severity and pervasiveness of all the problems addressed may be mild, moderate, or severe; they also may be narrow or pervasive in terms of how broadly they are manifested.

BEST COPY AVAILABLE

Exhibit 2: A Graphic Representation of the Problem of Barriers to Learning


Range of Learners
(categorized in terms of their response to academic instruction)
I = Motivationally ready & able
II = Not very motivated/ lacking prerequisite knowledge & skills/ different learning rates & styles/ minor vulnerabilities
III = Avoidant/very deficient in current capabilities/ has a disability/ major health problems
No Barriers
Barriers to Learning
Instructional Component
Desired Outcome

Efforts to Expand School-Related Health and Social Services

Over the last decade, leaders for an expanded focus on health in schools have advocated for an eight component model to ensure a comprehensive approach (Allensworth, Wyche, Lawson, & Nicholson, 1997; Kolbe, 1993). The eight components are (1) health education, (2) health services, (3) biophysical and psychosocial environments, (4) counseling, psychological, and social services, (5) integrated efforts of schools and communities to improve health, (6) food service, (7) physical education and physical activity, and (8) health programs for faculty and staff.

The focus on comprehensive school health is admirable. It is not, of course, a comprehensive approach for addressing a full range of barriers to learning -- nor does it profess to be. Moreover, its restricted emphasis on health tends to engender resistance from school policy makers who do not think they can afford a comprehensive focus on health and still accomplish their primary mission to educate students.

Reform-minded policy makers may be more open to proposals encompassing a broad range of programs to enhance healthy development if such programs are part of a comprehensive approach for addressing barriers to learning.

Some are suggesting that the *school-linked services* movement, especially in the form of full service schools is the answer. And each day brings additional reports from projects such as New Jersey's School-Based Youth Services Program, the Healthy Start Initiative in California, the Beacons Schools in New York, Communities-in-Schools, and the New Futures Initiative.

A review by Michael Knapp (1995) underscores the fact that the literature on school-linked services is heavy on advocacy and prescription and light on findings. Not surprisingly, findings primarily reflect how hard it is to institutionalize such approaches. Keeping the difficulties in mind, a reasonable inference from available data is that school-community collaborations can be successful and cost effective over the long-run.

Outstationing community agency staff at schools allows easier access for students and families -- especially in areas with underserved and hard to reach populations. Such efforts not only provide services, they seem to encourage schools to open their doors in ways that enhance family involvement. Analyses suggest better outcomes are associated with empowering children and families and having the capability to address diverse constituencies and contexts. Families using school-based centers are described as becoming interested in contributing to school and community by providing social support networks for new students and families, teaching each other coping skills, participating in school governance, and helping create a psychological sense of community.

At the same time, it is clear that initiatives for school-linked services produce tension between school district *pupil services personnel* and their counterparts in community-based organizations. When "outside" professionals are brought in, school specialist staff often view the move as discounting their skills and threatening their jobs. These concerns are aggravated whenever policy makers appear to overestimate the promise of school-linked services with regard to addressing the full range of barriers to learning. And, ironically, by downplaying school-owned resources, the school-linked services movement has allowed educators to ignore the need for restructuring the various education support programs and services that schools own and operate.

A continuum is outlined in Exhibit 3 to illustrate a comprehensive range of programs to address barriers to learning and enhance healthy development. As can be seen, the continuum ranges from programs for primary prevention (including the promotion of mental health) and early-age intervention --through those for addressing problems soon after onset-- on to treatments for severe and chronic problems. In doing so, it encompasses prevention and prereferral interventions for mild problems, high visibility programs for high-frequency psychosocial problems, and strategies to assist with severe and pervasive mental health problems. Such an approach recognizes the role school, home, and community life play in creating and correcting young people's problems, especially those who are under-served and hard-to-reach.

With respect to *comprehensiveness*, the programs outlined highlight that many problems must be addressed developmentally and with a range of programs -- some focused on individuals and some on environmental systems, some focused on mental health and some on physical health, education, and social services. With respect to concerns about *integrating* programs, the continuum underscores the need for concurrent interprogram linkages and for linkages over extended periods of time. From such a perspective, schools must provide interventions that address individual problems and system changes. At the same time, schools must continue to explore formal and informal ways to link with public and private community agencies.

Exhibit 3: From Primary Prevention to Treatment of Serious Problems: A Continuum of Community-School Programs

Intervention Continuum	*Examples of Focus and Types of Intervention* (Programs and services aimed at system changes and individual needs)
Primary prevention	1. Public health protection, promotion, and maintenance to foster opportunities, positive development, and wellness • economic enhancement of those living in poverty (e.g., work/welfare programs) • safety (e.g., instruction, regulations, lead abatement programs) • physical and mental health (incl. healthy start initiatives, immunizations, dental care, substance abuse prevention, violence prevention, health/mental health education, sex education and family planning, recreation, social services to access basic living resources, and so forth)
Early-after-onset intervention	2. Preschool-age support and assistance to enhance health and psychosocial development • systems' enhancement through multidisciplinary team work, consultation, and staff development • education and social support for parents of preschoolers • quality day care • quality early education • appropriate screening and amelioration of physical and mental health and psychosocial problems
	3. Early-schooling targeted interventions • orientations, welcoming and transition support into school and community life for students and their families (especially immigrants) • support and guidance to ameliorate school adjustment problems • personalized instruction in the primary grades • additional support to address specific learning problems • parent involvement in problem solving • comprehensive and accessible psychosocial and physical and mental health programs (incl. a focus on community and home violence and other problems identified through community needs assessment)
	4. Improvement and augmentation of ongoing regular support • enhance systems through multidisciplinary team work, consultation, and staff development • preparation and support for school and life transitions • teaching "basics" of support and remediation to regular teachers (incl. use of available resource personnel, peer and volunteer support) • parent involvement in problem solving • resource support for parents-in-need (incl. assistance in finding work, legal aid, ESL and citizenship classes, and so forth) • comprehensive and accessible psychosocial and physical and mental health interventions (incl. health and physical education, recreation, violence reduction programs, and so forth) • Academic guidance and assistance • Emergency and crisis prevention and response mechanisms
	5. Other interventions prior to referral for intensive and ongoing targeted treatments • enhance systems through multidisciplinary team work, consultation, and staff development • short-term specialized interventions (including resource teacher instruction and family mobilization; programs for suicide prevention, pregnant minors, substance abusers, gang members, and other potential dropouts)
Treatment for severe/chronic problems	6. Intensive treatments • referral, triage, placement guidance and assistance, case management, and resource coordination • family preservation programs and services • special education and rehabilitation • dropout recovery and follow-up support • services for severe-chronic psychosocial/mental/physical health problems

What Do Schools Offer Related to Mental Health?

Schools clearly are involved in dealing with barriers to learning. Newcomers to school settings often are not aware that schools do own and operate a variety of mental health and psychosocial programs and services. They hire pupil service professionals and institute services and programs aimed at such concerns as drug abuse, teen pregnancy, dropout prevention, and on and on. In addition, efforts increasingly are made to link with community health and social services.

How Much is Offered?

In large school districts, one finds an extensive range of preventive and corrective activity oriented to students' problems. Some programs are provided throughout a district, others are carried out at or linked to targeted schools. The interventions may be offered to all students in a school, to those in specified grades, or to those identified as "at risk." The activities may be implemented in regular or special education classrooms or as "pull out" programs and may be designed for an entire class, groups, or individuals. With specific respect to mental health, the full range of topics arise -- including matters related to promoting mental health, minimizing the impact of psychosocial problems, managing psychotropic medication, and participating in systems of care. It is common knowledge, however, that few schools come close to having enough resources to deal with a large number of students with mental health and psychosocial problems. Most schools offer only bare essentials.

Federal and state mandates play a significant role in determining how many pupil services professionals are employed. Based on a sample of 482 districts of varying sizes in 45 states, recent data indicate that 55% report having counselors; 40.5% have psychologists; 21% have social workers; and 2.1% have psychiatrists (Davis, Fryer, White, & Igoe, 1995). In general, the ratio for school psychologists or school social workers averages 1 to 2500 students; for school counselors, the ratio is about 1 to 1000 (Carlson, Paavola, & Talley, 1995). Given estimates that more than half the students in many schools are encountering major barriers that interfere with their functioning, such ratios inevitably mean that more than narrow-band approaches must be used if the majority are to receive the help they need (Fleisch, Knitzer, & Steinberg, 1990).

Types of Interveners and Their Functions

In assisting teachers, specialists with mental health orientations tend to focus on students seen as problems or as having problems. The many functions of such specialists can be grouped into three categories

(1) direct services and instruction,

(2) coordination, development, and leadership related to programs, services, resources, and systems,

(3) enhancing connections with community resources.

Prevailing direct intervention approaches encompass identification of the needs of targeted individuals, prescription of one or more interventions, brief consultation, and gatekeeping procedures (such as referral for assessment, corrective services, triage, and diagnosis). In some situations, however, resources are so limited that school staff can do little more than assess for special education eligibility, offer brief consultations, and make referrals to special education and/or community resources. Well-developed systems include mechanisms for case coordination, ongoing consultation, program development, advocacy, and quality assurance. There also may be a focus on primary prevention and enhancement of healthy development through use of health education, health services, guidance, and so forth -- though relatively few resources usually are allocated for such activity.

Because resources are so limited, efforts to address barriers to learning and enhance healthy development are not seen as the sole province of professionals/specialists. Professionals trained to provide mental health interventions have a special role to play. But so do all staff hired by a school, and so do students, family members, community agency personnel, volunteers, and so forth; all can and should be part of efforts to address mental health and psychosocial concerns.

All the efforts are meant to contribute to reduction of problem referrals, an increase in the efficacy of mainstream and special education programs, and enhanced instruction and guidance that fosters healthy development. When given the opportunity personnel dealing with mental health and psychosocial concerns also can contribute to program development and system reform, as well as helping enhance school-community collaborations.

> Exhibit 4 outlines the types of interveners and specific functions related to meeting psychosocial and mental health needs found in schools.

Even though poor health and other barriers to student learning are seen as directly related to poor educational outcomes, programs to address barriers to learning are treated as "add-on." That is, in terms of policy and practice, they are not assigned top priority and often are among the first cut when budgets are tight. As long as this is the case, many students will continue to be cut off from the benefits of instructional reforms. And for schools serving large numbers of such students, this means continuation of the pattern of test score averages that do not rise substantially. This is a central paradox of school reform. That is: school restructuring clearly is intended to enhance student achievement. To this end, reform efforts predominantly focus on improving instruction and school management, with little attention paid to *restructuring and enhancing resources that address barriers to learning.* Consequently, too many students are unable to take advantage of improved teaching.

Where Does a School-Based Health Center Fit In?

As long as so many students have social, emotional, and physical health deficits and other persistent barriers to learning, schools must find increasingly more potent ways to address such factors so that these youngsters can benefit appropriately from their schooling. This includes enhancing healthy development.

Exhibit 4: Types of Interveners and Functions

I. Interveners Who May Play Primary or Secondary Roles in Carrying Out Functions Relevant to Mental Health and Psychosocial Concerns

Instructional Professionals
(e.g., regular classroom teachers, special education staff, health educators classroom resource staff and consultants)

Administrative Staff
(e.g., principals, assistant principals, deans)

Health Office Professionals
(e.g., nurses, physicians, health educators, consultants)

Counseling, Psychological, and Social Work Professionals
(e.g., counselors, health educators, psychologists, psychiatrists, psychiatric nurses, social workers, consultants)

Itinerant Therapists
(e.g., art, dance, music, occupational, physical, speech-language-hearing, and recreation therapists; psychodramatists)

Personnel-In-Training

Others
- Aides
- Classified staff (e.g., clerical and cafeteria staff, custodians, bus drivers)
- Paraprofessionals
- Peers (e.g., peer/cross-age counselors and tutors, mutual support and self-help groups)
- Recreation personnel
- Volunteers (professional/paraprofessional/ nonprofessional -- including parents)

II. Functions Related to Addressing Mental Health and Psychosocial Needs at the School and District Level

Direct Services and Instruction
(based on prevailing standards of practice and informed by research)
- Crisis intervention and emergency assistance (e.g., psychological first-aid and follow-up; suicide prevention; emergency services, such as food, clothing, transportation)
- Assessment (individuals, groups, classroom, school, and home environments)
- Treatment, remediation, rehabilitation (incl. secondary prevention)
- Accommodations to allow for differences and disabilities
- Transition and follow-up (e.g., orientations, social support for newcomers, follow-thru)
- Primary prevention through protection, mediation, promoting and fostering opportunities, positive development, and wellness (e.g., guidance counseling; contributing to development and implementation of health and violence reduction curricula; placement assistance; advocacy; liaison between school and home; gang, delinquency, and safe-school programs; conflict resolution)
- Increasing the amount of direct service impact through multidisciplinary teamwork, consultation, training, and supervision

Coordination, Development, and Leadership Related to Programs, Services, Resources, and Systems
- Needs assessment, gatekeeping, referral, triage, and case monitoring/management (e.g., participating on student study/assistance teams; facilitating communication among all concerned parties)
- Coordinating activities (across disciplines and components; with regular, special, and compensatory educ.; in and out of school)
- Mapping and enhancing resources and systems
- Developing new approaches (incl. facilitating systemic changes)
- Monitoring and evaluating intervention for quality improvement, cost-benefit accountability, research
- Advocacy for programs and services and for standards of care in the schools
- Pursuing strategies for public relations and for enhancing financial resources

Enhancing Connections with Community Resources
- Strategies to increase responsiveness to referrals from the school
- Strategies to create formal linkages among programs and services

BEST COPY AVAILABLE

The school-based health center movement is contributing to this effort and is in a position to play a special catalytic role in improving approaches for addressing barriers to student learning. This movement was created in response to concerns about teen pregnancy and a desire to enhance access to physical health care for underserved youth. Soon after opening, most clinics find it essential also to address mental health and psychosocial concerns. The need to do so reflects two basic realities. One, some students' physical complaints are psychogenic, and thus, treatment of various medical problems is aided by psychological intervention. Two, in a large number of cases, students come to clinics primarily for help with nonmedical problems, such as personal adjustment and peer and family relationship problems, emotional distress, problems related to physical and sexual abuse, and concerns stemming from use of alcohol and other drugs.

Thus, as these centers evolve, so does the provision of counseling, psychological, and social services in the schools. At the same time, given the limited number of staff at such clinics, it is not surprising that the demand for psychosocial interventions quickly outstrips the resources available. Without a massive infusion of money, school-based and linked health centers can provide only a restricted range of interventions to a limited number of students. Thus, the desire of such centers to be comprehensive centers in the full sense of the term remains thwarted.

Policy initiatives to restructure community health and human services have fostered the concept of *school-linked services* and contributed to a burgeoning of school--based and linked health and family resources centers (Advocates for Youth, 1994; Dryfoos, 1994; U.S. Department of Education, 1995). The intent in encouraging linkages between schools and community agencies is to increase efficacy by enhancing comprehensiveness, case management, integration of resources, accessibility, and use of services by students and their families. The movement also underscores the importance of offering mental health in schools. For example, at many of the now over 1000 school-based or linked health centers, up to 50% of student visits are for psychosocial concerns (Adelman, Barker, & Nelson, 1993; Anglin, Naylor, & Kaplan, 1996; Robert Wood Johnson Foundation, 1989).

Dryfoos (1994, 1995) encompasses the trend to develop school-based primary health clinics, youth service programs, community schools, and other similar activity under the rubric of *full service schools.* (She credits the term to Florida's comprehensive school-based legislation.) As she notes in her review:

> Much of the rhetoric in support of the full service schools concept has been presented in the language of *systems change,* calling for radical reform of the way educational, health, and welfare agencies provide services. Consensus has formed around the goals of one stop, seamless service provision, whether in a school- or community-based agency, along with empowerment of the target population. ... most of the programs have moved services from one place to another; for example, a medical unit from a hospital or health department relocates into a school through a contractual agreement, or staff of a community mental health center is reassigned to a school, or a grant to a school creates a coordinator in a center. As the program expands, the center staff work with the school to draw in additional services, fostering more contracts between the schools and community agencies. But few of the school systems or the agencies have changed their governance. The outside

> agency is not involved in school restructuring or school policy, nor is the school system involved in the governance of the provider agency. The result is not yet a new organizational entity, but the school is an improved institution and on the path to becoming a different kind of institution that is significantly responsive to the needs of the community (p. 169).

Full service schools reflect the desire for comprehensiveness; the reality remains much less than the vision. As long as such efforts are shaped primarily by a school-linked services model (i.e., initiatives to restructure community health and human services), resources will remain too limited to allow for a comprehensive continuum of programs.

A Multifaceted and Catalytic Role for School-Based Health Centers

Those in the school-based health center movement are confronted with many challenges. Key among these are:

- How can school-based health centers best use their limited resources in responding to the increasing volume of psychosocial problems they encounter?
- How can a center help produce better outcomes for those experiencing problems?

Central to meeting such challenges is working together with school, family, and community to use existing resources more effectively and in the process build more comprehensive approaches.

A Multifaceted Focus

She's depressed.

That kid's got an attention deficit hyperactivity disorder.

He's learning disabled.

In discussing mental health, it is easy to fall into the trap of thinking only in terms of psychopathology. As the noted anthropologist Ruth Benedict wisely noted:

> Normality and exceptionality (or deviance) are not absolutes; both are culturally defined by particular societies at particular times for particular purposes.

Not only is it easy to think only in terms of psychopathology; it is easy to fall into the trap of thinking about the causes of problems only in terms of the individual -- ignoring the role of the environment or system.

A *multifaceted approach* deals with both the *individual and the system.*

Addressing System Supports

Mental health professionals must not ignore the social bases of a student's problems. This means attending to environmental concerns such as basic housing and daily survival needs, family and peer relations, and school experiences.

Individual-focused interventions aimed at deficiencies in system supports may range from helping a student find adequate clothing to eliciting support of school staff to protect a youngster from harassment by gang members. To improve students' daily living and school situations, there is a need to work with school staff to address how the school might improve its programs to counter prevailing frustration, unhappiness, apathy, and hopelessness. In general, this involves interventions that expand students' opportunities in ways that increase expectations about a positive future.

Individual, Group, Family

In designing interventions and making referrals, the matter of individual, group, or family counseling arises. Related matters are those of home visits, working through others, and referring to nontraditional programs such as peer counseling.

Although the first inclination may be to think in terms of providing or referring a student for individual counseling, an effective mental health focus requires appreciating the value of group and peer support. Besides the documented therapeutic benefits that many individuals derive from working in groups and with peers, these approaches have the advantage of allowing programs to provide direct service to a greater number of persons. With demand as large as it is and resources as limited as they are, this is no small consideration.

Some students, of course, cannot address their problems effectively in a group setting or to peers -- at least initially. In some cases, such students also are found to have such extensive problems that long-term intervention is the treatment of choice, and the center's time is best spent helping them connect with a service that can provide extended treatment.

If a student's problems are based mainly in the home, the intervention often needs to focus on the parents rather than the student. This may mean offering parents a few counseling sessions at the center or referrals to other counseling services. The student may not even need to be involved in such counseling (e.g., if her or his problems are simply a by-product of the parents' behavior). Of course, if the parents won't change, the student may need help to cope with and minimize the impact of the negative home situation.

Teacher:

Cara showed up today bruised and battered. We think her dad is abusing her.

A parent to a school nurse:

I don't know what to do with Matt. He always seems angry and won't do any school work. I'm so depressed, I can hardly deal with him any more.

Parent involvement in schools is a prominent item on the education reform agenda. As Epstein (1987) notes, "the evidence is clear that parental encouragement, activities, and interest at home and participation in schools and classrooms affect children's achievements, attitudes, and aspirations, even after student ability and family socioeconomic status are taken into account."

Home involvement is especially important when students have problems. Clearly, families play a key role in causing and sometimes maintaining a student's problems. They also can play a major role in correcting or at least minimizing problems. And, any family that has a youngster with a problem is likely to pay a price economically, psychologically, and socially.

In all cases, besides whatever direct health and human services the family requires, there may also be a need for social and emotional support.

Think about the families of the students who are referred to you because of problems.

How do the school and center interact with family members? Do family members see school and center staff as allies? If not, why not?

Parents and other caretakers find it difficult to attend to the needs of their children when their own pressing needs are not attended to. This may help account for why parents who are most receptive to efforts to involve them in schools and schooling are a relatively small group.

> Parents and others in the home need to feel welcomed and appreciated by the school.
>
> Parents and others in the home often need to have an opportunity to share concerns.
>
> Parents and others in the home need good information when there are problems -- information about the problem and presentation of such information in a context that also recognizes assets.
>
> Parents and others in the home need information and ready access to resources.

In situations where large numbers of students are having problems, the need is for healthy families, healthy schools, and healthy communities. It seems likely that efforts to involve increasing numbers of parents in improving the well-being of their children must include a focus on improving the well-being of the many parents who are struggling to meet their own basic personal and interpersonal needs.

Thus, schools must be prepared to add programs and services that address such basic needs and staff must reach out to parents with interventions that are welcoming and encourage use of such programs. At the same time, schools must resist the temptation to scold such parents.

A Comprehensive Approach

> *She said she wanted information about dieting. Then, she burst into tears. Slowly, painfully, the quiet desperation spilled out. She felt stupid and ugly. School was a burden; home was a mess. The only way to get boys was to give them whatever they wanted. But none of them wanted her for long. Nothing seemed to be working out; living seemed too hard.*

Meeting the needs of youngsters often requires a blending of expertise. Preventing unwanted pregnancies can be as much a matter of affecting attitudes as anything else. Physical complaints often are rooted in psychosocial problems. Schools and school-based health centers are confronting large numbers of students who report serious emotional turmoil, feelings of depression, substance abuse, and histories of physical and sexual assault.

The Need to Improve the Response

At this stage in the evolution of school-based mental health programs, services are introduced quickly in response to pressing needs. As a result, coordinated service plans often have not been developed.

For example, both the school and center may operate parallel substance abuse programs, while neither offers a suicide prevention program. Or, a student may be receiving counseling at a school-based health center and also be in a school-based substance abuse program, with neither program aware of the student's involvement with the other.

- Lack of *coordination and integration among programs* tends to work against long-term effectiveness.

- Similarly, lack of a reasonably *comprehensive range of intervention options* works against meeting the needs of many students.

Needed: Coordinated Action

As noted, minimally there is a need for coordination among school district programs and between such programs and those offered by school-based health centers.

Coordination of programs in order to improve effectiveness require

- *cooperative working relationships* among center, school, and community programs

- *case monitoring and problem solving* with respect to individual students -- in ways that appropriately account for confidentiality

Integration of programs involves blending and restructuring of resources.

Needed: Expanded Intervention Options

Principles of intervention (such as treating the *whole person,* providing the *best fit,* and using the *least intervention needed*) stress the importance of a comprehensive and coordinated set of options that can lead to

- a good *match* with a student's *needs*

- use of procedures that are *no more intrusive and restrictive than is essential.*

Such principles suggest the need for a range of interveners and intervention options. Exhibit 5 provides examples with a specific focus on the role of a SBHCs mental health professional.

And, once good coordination is established, it is time to focus on expanding the range of available intervention options with a view to comprehensiveness and integration of activity.

Such a focus includes interventions to both correct existing problems and prevent future ones. That is,

- service options to increase the likelihood of a good intervention match for a particular student

- prevention and positive mental health programs (mental health education)

- activities designed to improve the school's psychosocial climate.

Anyone seeing school-based health center staff in action as they pursue their many tasks knows they are more than busy. They are inundated with referrals for students whose problems stem from a variety of problems.

Exhibit 5: Examples of the Range of Interveners and Interventions Needed

Type of Intervener	*Examples of Interventions*
1. Self-help (Role for center's staff is to make information readily available to students and facilitate organization of groups)	•printed materials •information phone lines •resource references •general support groups •specific problem-oriented groups
2. Family/friends/interested others (Role of center's staff is to connect student with social/economic supports and monitor results)	Connect student with •personal advocate(s) •adopt a student program •clubs, teams, and other recreation activities to expand social contacts •part time employment
3. Volunteer aides/tutors/peer counselors (Center's staff can help establish programs and, if feasible, help recruit, supervise, and case coordinate)	•academic support •counseling by peers
4. Regular school staff (Center's staff can help develop programs to recruit, train, and establish collaborative and consultation relationships with regular school staff)	•academic support •counseling •provide special status roles at school for alienated students •mental health education for students/parents •crisis intervention
5. Special support staff -- including school-based health center staff and professionals from the community who provide services at school (Role of center's staff is referral, case management, or direct intervention)	•assessment •consultation about a student and/or the school's psychosocial climate •advocacy •extra academic support •mental health education •short-term counseling or therapy (individual/group/family) •collaborative counseling •crisis intervention •referral to district or community services to address basic survival needs (personal/academic)
6. District support services or community services (Role of center's staff is referral)	•assessment •advocacy •consultation about a student and/or the school's psychosocial climate •extra academic support •MH education •short-term counseling or therapy (individual/group/family) •collaborative counseling •crisis intervention •referral to other services and special placement considerations to address basic survival needs

Many staff want to redesign their roles so that they can work more intensively with others at a school site to maximize the impact schools have on addressing the most profound barriers causing students to fall by the wayside. And all this has the potential not only to enhance the success of a great many more youngsters, but also should prove more satisfying to the professionals involved.

How can this be done? "Not by working harder, but by working smarter." One essential element in working smarter is to have an enhanced conceptual base for understanding what is meant by "a comprehensive approach.

Direct Services and More

To be comprehensive, the mental health focus of school-based centers must be multifaceted. As indicated in Exhibit B, three groupings of primary and complementary functions are fundamental in meeting mental health and psychosocial needs: (1) direct services and instruction, (2) coordination, development, and leadership related to programs, services, resources, and systems, and (3) enhancing connections with community resources.

Obviously, maintaining such a breadth of focus is difficult. The difficulty is reduced when centers work to integrate their practices and resources with others at the school and in the community. Accomplishing this often requires the center to play a catalytic role first to build mechanisms for communication and networking and then to create mechanisms for building a comprehensive, integrated approach to addressing barriers to effective student functioning.

Programmatic Approaches: Going Beyond Clinical Interventions

A large number of young people are unhappy and emotionally upset; only a small percent are clinically depressed. A large number of youngsters behave in ways that distress others; only a small percent have ADHD or a conduct disorder. In some schools, the majority of students have garden variety learning problems; only a few have learning disabilities. Thankfully, those suffering from true internal pathology represent a relatively small segment of the population. Society must never stop providing the best services it can for such individuals and doing so means taking great care not to misdiagnose others whose "symptoms" may be similar but are caused to a significant degree by factors other than internal pathology. Such misdiagnoses lead to policies and practices that exhaust available resources in serving a relatively small percent of those in need. That is a major reason why there are so few resources to address the barriers interfering with the education and healthy development of so many youngsters who are seen as troubled and troubling.

Because behavior, emotional, and learning problems usually are labelled in ways that overemphasize internal pathology, it is not surprising that helping strategies take the form of clinical/remedial intervention. And for the most part, such interventions are developed and function in relative isolation of each other. Thus, they represent another instance of using piecemeal and fragmented strategies to address complex problems.

One result is that an individual identified as having several problems may be involved in programs with several professionals working independently of each other. Similarly, a youngster identified and treated in special infant and pre-school programs who still requires special support may cease to receive appropriate help upon entering school. And so forth.

Dealing with a full continuum of concerns requires a comprehensive and integrated programmatic approach. Such an approach may require one or more mental health, physical health, and social services. That is, any one of the problems may require the efforts of several programs, concurrently and over time. This is even more likely to be the case when an individual has more than one problem. And, in any instance where more than one program is indicated, it is evident that interventions should be coordinated and, if feasible, integrated.

Establishing a comprehensive, integrated approach is excruciatingly hard. Efforts to do so are handicapped by the way interventions are conceived and organized and the way professionals understand their functions. Conceptually, intervention rarely is envisioned comprehensively. Organizationally, the tendency is for policy makers to mandate and planners and developers to focus on specific programs. Functionally, most practitioners and researchers spend most of their time working directly with specific interventions and samples and give little thought or time to comprehensive models or mechanisms for program development and collaboration. Consequently, programs to address physical, mental health, and psychosocial problems rarely are coordinated with each other or with educational programs.

With respect to addressing barriers to learning, comprehensiveness requires more than

- ***a focus on health and social services***
- ***outreach to* link with *community* resources**
- ***coordination* of *school-owned* services**
- ***coordination* of *school and community* services.**

Moving toward comprehensiveness in addressing barriers to learning encompasses restructuring, transforming, and enhancing

- **all relevant school-owned programs and services**
- **community resources and**
- **weaving these school and community resources together.**

BEST COPY AVAILABLE

Organizations that Can Be Useful Resources to School-Based Health Center Staff

There are a host of organizations that can provide SBHC's with technical assistance, consultation, materials, continuing education, and so forth. One relatively easy way to obtain reference to most of these agencies is to obtain the following aid packets from the our Center:

Catalogue *of Internet Sites Relevant to Mental Health in Schools*

Contains a compilation of internet resources and links related to addressing barriers to student learning and mental health in schools. (Updated regularly)

Organizations with Resources Relevant to Addressing Barriers to Learning:* A Catalogue *of Clearinghouses, Technical Assistance Centers, and Other Agencies

Categorizes and provides contact information on organizations focusing on children's mental health, education and schools, school-based and school-linked centers, and general concerns related to youth and other health related matters. (Updated regularly)

Where to Get Resource Materials to Address Barriers to Learning

Offers school staff and parents a listing of centers, organizations, groups, and publishers that provide resource materials such as publications, brochures, fact sheets, audiovisual & multimedia tools on different mental health problems and issues in school settings.

***Clearinghouse* Catalogue**

Our Clearinghouse contains a variety of resources relevant to the topic of mental health in schools. This annotated catalogue classifies these materials, protocols, aids, program descriptions, reports, abstracts of articles, information on other centers, etc. under three main categories: policy and system concerns, program and process concerns, and specific psychosocial problems. (Updated regularly)

***Consultation Cadre* Catalogue**

Provides information for accessing a large network of colleagues with relevant experiences related to addressing barriers to student learning and mental health in schools. These individuals have agreed to share their expertise without charging a fee. The catalogue includes professionals indicating expertise related to major system and policy concerns, a variety of program and process issues, and almost every type of psychosocial problem. (Updated regularly)

As a beginning, you should pay special attention to the following organizations because of their direct interest in SBHCs and/or child/youth health and mental health. Minimally, each provides a variety of Fact Sheets on mental health and psychosocial concerns. They also will provide catalogues on their various publications -- many of which are topical and relatively inexpensive. If you have access to the Internet, you can check out their websites and find out what they offer you.

Advocates for Youth
1025 Vermont Avenue, NW
Washington, DC 20005
Ph. 202/347-5700
Fax: 202/347-2263

American Academy of Child &
Adol. Psychiatry
3615 Wisconsin Avenue, NW
Washington, DC 20005
Ph. 202/966-7300
Fax: 202/966-2891
Website: http://www.aacap.org

American Psychological Association
750 First Street, NE
Washington, DC 20002-4242
Ph: 202/336-5500
Website: http://www.apa.org/

Center for Mental Health Services
Office of External Liaison
Substance Abuse and Mental Health
Services Administration
5600 Fishers Lane, Suite 13-103
Rockville, MD 20857
Ph: 301/443-9848
Fax: 301/443-5163
email: vmontgom@samhsa.gov

ERIC Clearinghouse for Counseling
and Student Services
Ph: 800/414-9769
Fax: 910/334-4114
Website: http://www.uncg.edu/~ericas2/

Federation of Families for Children's
Mental Health
1021 Prince St.
Alexandria, VA 22314-2971
Ph: 703/684-7710
Fax: 703/836-7710
Website: http://www.ffcmch.org/
email: ffcmh@crosslink.net

National Association of School Psychologists
4340 East West highway, Suite 402
Bethesda, MD 20814
Ph: 301/657-0270
Fax: 301/657-0275
Website: http://www.uncg.edu/~ericas2/nasp/
email: nasp8455@aol.com

National Association of Social Workers
50 First Street, NE
Washington, DC 20002-4241
Ph: 800/638-8799
Fax: 202/336-8310
Website: http://www.naswpress.org/

National Institute of Mental Health
Information Resources
5600 Fishers Lane, Room 7C-02
Rockville, MD 20857
Ph: 301/443-4513
Fax: 301/443-4279
Website: http://www.nimh.nih.gov/publicat/

National Maternal and Child
Health Clearinghouse
2070 Chain Bridge Rd., Suite 450
Vienna, VA 22182-2536
Ph: 703/821-8955
Fax: 703/821-2098
Websire: http://www.ichp.ufl.edu/

National Technical Assistance Center
for Children's Mental Health
3307 M Street, NW, Fourth Flr.
Washington, DC 20007-3935
Ph: 202/687-5000
Fax: 202/687-8899
Website:
http://www.dml.georgetown.educ/depts/pediatrics/
gucdc/index/html/
email: gucdc@medlib.georgetown.edu

And, of course, you should contact our sister center and us:

Center for School Mental Health Assistance
Dept. of Psychiatry
University of Maryland at Baltimore
680 West Lexington Street. 10th Flr.
Baltimore, MD 21201-1570
Ph: 888/706-0980
Fax: 410/706-0984
Website: http://csmha.ab.umd.edu/
email: csmha@csmha.ab.umd.edu

UCLA Center for Mental Health in Schools
Dept. of Psychology
405 Hilgard Ave.
Los Angeles, CA 90095-1563
Ph: 310/825-3634
Fax: 310/206-8716
Website: http://www.lifesci.ucla.edu/psych/mh/
email: smhp@ucla.edu

A Few Related References

For a fuller discussion of the topic of Mental Health in Schools, see

Taylor, L. & Adelman, H.S. (1996), Mental health in the schools: Promising directions for practice. *Adolescent Medicine: State of the Art Reviews, 7,* 303-317.

Adelman, H.S. (1995), Clinical psychology: Beyond psychopathology and clinical interventions. *Clinical Psychology: Science and Practice, 2,* 28-44.

Flaherty, L.T., Weist, M.D., & Warner, B.S. (1996). School-based mental health services in the United States: History, current models, and needs. *Community Mental Health Journal, 32,* 341-352.

Other References Cited or Relevant as Background

Adelman, H.S. (1996). *Restructuring support services: Toward a comprehensive approach.* Kent, OH: American School Health Association.

Adelman, H.S., & Taylor, L. (1997). Addressing barriers to learning: Beyond school-linked services and full service schools.. *American Journal of Orthopsychiatry, 67,* 408-421..

Adelman, H.S., Barker, L. A., & Nelson, P. (1993). A study of a school-based clinic: Who uses it and who doesn't? *Journal of Clinical Child Psychology, 22,* 52-59.

Allensworth, D., Wyche, J., Lawson, E., & Nicholson, L. (Eds.), (1997). *Schools and health: Our nation's investment.* Washington, DC: National Academy Press.

Anglin, T.M., Naylor, K.E., & Kaplan, D.W. (1996). Comprehensive, school-based health care: High school students' use of medical, mental health, and substance abuse services. *Pediatrics, 97,* 318-330.

Carlson, C., Paavola, J., & Talley, R. (1995). Historical, current, and future models of schools as health care delivery settings. *School Psychology Quarterly, 10,* 184-202.

Christopher, G.M., Kurtz, P.D., Howing, P.T. (1989). Status of mental health services for youth in school and community. *Children and Youth Services Review, 11,* 159-174.

Cohen, J.J., & Fish, M.C. (1993). *Handbook of school-based interventions: Resolving student problems and promoting healthy educational environments.* San Francisco: Jossey-Bass.

Conoley, J.C., & Conoley, C.W. (1991). Collaboration for school adjustment: Issues for school-and clinic-based psychologists. *Journal of Consulting and Clinical Psychology, 59,* 821-829.

Costello, E.J. (1989). Developments in child psychiatric epidemiology. *Journal of the American Academy of Child and Adolescent Psychiatry, 28,* 836-841.

Davis, M, Fryer, G.E., White, S., & Igoe, J.B. (1995). *A closer look: A report of select findings from the National School Health Survey 1993-4*. Denver, CO: Office of School Health, University of Colorado Health Sciences Center.

Dryfoos, J.G. (1990). *Adolescents at risk: Prevalence and prevention*. London: Oxford Press. .

Dryfoos, J.G. (1994). *Full-service schools: A revolution in health and social services for children, youth, and families.* San Francisco: Jossey-Bass.

Dryfoos, J. (1995). Full service schools: Revolution or fad? *Journal of Research on Adolescence, 5*, 147-172.

Geiger, K. (1995). L.A.'s Kids Courageous. *United Teacher, XXVI,* 14 & 19.

Hendren, R.L., Weisen, R.B., & Orley, J. (1994). *Mental health programs in schools.* Geneva: World Health Organization, Division of Mental Health.

Hoagwood, K. (1995). Issues in Designing and implementing studies of non-mental health care sectors. *Journal of Clinical Child Psychology, 23*, 114-120.

Hodgkinson, H.L. (1993). American education: The good, the bad, and the task. *Phi Delta Kappan, 74*, 619-623.

Igoe, J.B., & Giordano, B.P. (1992). *Expanding school health services to serve families in the 25th century*. Washington, DC: American Nursing Publications.

Kirby, D., Short, L., Collins, J., Rugg, D., Kolbe, L., Howard, M., Miller, B., Sonenstein, F., & Zabin, L.S. (1994). School-based programs to reduce sexual risk behaviors: A review of effectiveness. *Public Health Reports, 109*, 339-360.

Knapp, M.S. (1995). How shall we study comprehensive collaborative services for children and families? *Educational Researcher, 24*, 5-16.

Knitzer, J., Steinberg, Z., & Fleisch, B. (1990). *At the schoolhouse door: An examination of programs and policies for children with behavioral and emotional problems*. NY: Bank Street.

Kolbe, L.J. (1993). An essential strategy to improve the health and education of Americans. *Preventive Medicine, 22*, 544-560.

Larson, J. (1994). Violence prevention in the schools: A review of selected programs and procedures. *School Psychology Review, 23,* 151-164.

Lewis, K.S. (1995). *Infants and children with prenatal alcohol and drug exposure: A guide to identification and intervention.* North Branch, MN: Sunrise River Press.

Lewis, K., & Thomson, H. (1987). *Manual of school health.* Addison Wesley, 1987.

Martin, J. (Ed.) (1994). *School-based clinics that work.* Washington, DC: U.S. Department of Health and Human Services (Public Health Service, Health Resources and Services Administration).

Mitchell, A., Seligson, M., & Marx, F. (1989). *Early childhood programs and the public schools: Promise and practice.* Dover, MA: Auburn House.

National Education Goals Panel (1994). *Data for the National Education Goals Report. Volume One: National data.* Washington ,D.C.: U.S. GPO.

National Nursing Coalition for School Health (1995). School health nursing services: Exploring national issues and priorities. *Journal of School Health 65,* 369-389.

Newton, J. (1989). *The new school health handbook: A ready reference for school nurses and educators.* Englewood Cliffs, NJ: Prentice Hall.

Proctor, S.T. (1993). *School nursing practice: Roles and standards.* Scarborough, ME: National Association of School Nurses, Inc.

Robert Wood Johnson Foundation (1989). *Annual Report.* Princeton, NJ: Author.

Schonfeld, D.J. (1996). Talking with elementary school-age children about AIDS and death: Principles and guidelines for school nurses. *Journal of School Nursing, 12,* 26-32.

Schorr, L.B. (1988). *Within our reach: Breaking the cycle of disadvantage.* New York: Doubleday.

Slavin, R., Karweit, N., & Wasik, B. (1994). *Preventing early school failure: Research on effective strategies.* Boston: Allyn & Bacon.

Tyack, D.B., (1992). Health and social services in public schools: Historical perspectives. *The Future of Children, 2,* 19-31.

A Primer on Creating School-Based Health Centers

Shearer, C.A. (1995). *Where the kids are: How to work with schools to create elementary school-based health centers, A primer for health professionals.* Washington, DC: National Health & Education Consortium.

MENTAL HEALTH AND SCHOOL-BASED HEALTH CENTERS

Module I

Addressing the Problem of Limited Center Resources

Every Noble Work is at first impossible.
Thomas Carlyle

School-Based Health Centers are confronted with many challenges -- not enough money, too few staff, inadequate space, too many clients, difficulty working with school staff, and more. Obviously, there are no simple solutions to such complex concerns. But in terms of the mental health focus of a center, the key is to use the limited resources to foster enhanced coordination and integration of center, school, and community resources. This requires outreach and networking with other professionals at the school site, in the district, at other centers, and at universities. One extremely productive mechanism is a coordinating team consisting of center and interested school staff and community members.

Within the center, daily interactions and weekly meetings facilitate essential sharing and collaboration. To connect mental health professionals and other interested staff from centers located near each other, bimonthly meetings and periodic workshops addressing mental health concerns are invaluable.

Maintaining good working relationships is hard work, but the rewards are immense. Such networking stimulates cooperation and coordination; it also generates support and ideas for improving both the quality and quantity of school-based mental health interventions. Ironically, it often is the case that individuals who are too busy to take an hour to meet and plan spend countless hours trying to catch up.

Units:

A. Meeting the Challenge of Limited Financial Resources
B. Integrating Activity to Maximize Resource Use and Effectiveness
Coda: Enhancing Available Resources

BEST COPY AVAILABLE

Module I

Addressing the Problem of Limited Center Resources

Contents

UNIT IA

Page

Meeting the Challenge of Limited Financial Resources IA-1

- Finding the Funds IA-1
- Optimizing the Use of the Center's Mental Health Professional IA-7
    - >Proposed Tasks for 10 Hours IA-7
    - >Added Tasks for a 20 hour Week IA-9
    - >30 or More Hours IA-9
    - >Starting From Zero IA-10

Resource Aids IA-11

UNIT IB

Integrated Activity to Maximize Resource Use and Effectiveness

- Working Together with School and Community
- Overcoming Barriers to Working Together
- One Other Observation

Coda: Enhancing Available Resources

Resource Aids

A Few Related References

BEST COPY AVAILABLE

Exhibits and Resource Aids in Module I

Exhibits

Page

Unit IA

6. Funding Sources for School Based Health Programs IA-2

Unit IB

7. Some General Guidelines for Establishing School Site Collaborative Teams

8. Planning and Facilitating Effective Meetings

9. Accounting for Cultural, Racial, and Other Significant Individual and Group Differences

Resource Aids

Unit IA

IA-1. Examples of Federal Resources IA-12

Unit IB

IB-1. Survey Instruments to Aid in Mapping and Analyzing Existing School-Based/Linked Psychosocial and Mental Health Systems, Programs, and Services

IB-2 Developing a Resource Coordinating Team

IB-3 Developing a Complex (Multisite) Resource Coordinating Council

BEST COPY AVAILABLE

Unit IA
Meeting the Challenge of Limited Financial Resources

Centers, schools, districts, and communities vary tremendously with respect to accessibility to services. No locale has enough resources; some are relatively well off; some are extremely impoverished.

> For example, adolescent-focused substance abuse programs often do not exist in a locale or may only be accessible to those who can pay the costs directly or through third party payers. Where no-cost programs exist, long waiting lists are commonplace.

Limited availability is an unavoidable reality and an ongoing challenge to all health professionals.

Limited availability, of course, is directly related to financial support. In an era of dwindling support for many public agencies, the most fundamental challenge for most school-based health centers and a variety of other related programs is how to survive.

> Meeting this challenge involves expanding a center's base of support and organizing for advocacy and action. With respect to advocacy, the key is not to compete with related school and community programs but to move toward fully integrating with such efforts. The need is to convince policy makers that all elements can be woven together to address barriers to learning and enhance healthy development in ways that are essential to school success.

Finding the Funds

For most centers, finding the funds to underwrite its activities remains a struggle. Because no single funding source is reliable, many centers seek diversified financial support and draw from the public and private sector (i.e., from individuals, agencies, and foundations at local, state, and national levels).

Exhibit 6 outlines a range of funding sources for school-based health centers.

> As centers become more integrated into school and community programs, some support can be derived from the funding that underwrites these programs. An example of possibilities is seen in Resource Aid IA-1 which outlines sources of federal support available to school districts.

Exhibit 6: Funding Sources for School Based Health Programs
(prepared by Bernice Rosenthal, MPH, Baltimore City Health Dept.)

SOURCE OF FUNDS/ CATEGORIES	HOW TO ACCESS OPTIONS	USE OF REVENUES IN BALTIMORE
General Funds: Local Health Dept. Budget	Determined by municipal government See local Health Departments	Budget for school nurses, aides, MDs, clerical, administration
Federal : EPSDT Administrative	Application to State EPSDT Office for administrative federal financial participation for expenditures related to outreach and case management that support the effort to assure that pregnant women and children with MA or likely to be eligible for MA receive preventive health services	Applied to school nurse salaries who provide administrative outreach and case management. Results in having local funds available for the SBC program.
MCH Title V (C and Y)	Application to agency delegated by State to distribute funds for primary health care for uninsured children.	Supports core staff in 3 school-based health centers.
STATE: Legislative	Bill initiated by state senator.	$41,000 for 1 PNP in designated school
HMO Reimbursement Out of Plan Family Planning Provider (SBHC)	Per State HMO contract, bill HMO for Family Planning services as out of plan provider.	Added to resource pool for expanding services in school clinics.
Pre-authorized services (SBHC)	Contract to complete EPSTD screens for HMO enrollees in SBHC schools.	Fee for service reimbursement.
Fee for service: School-Based Clinics (SBHCs)	Apply for Medicaid Provider status. Arrange for revenues to be retained by program without requirement to spend in year of receipt.	Used to expand staff with part-time NPS, Medical assistants, physician preceptors, and contracts for mental health clinicians.

(cont.)

Exhibit 6: Funding Sources for School Based Health Programs (cont.)

SOURCE OF FUNDS/ CATEGORIES	HOW TO ACCESS OPTIONS	USE OF REVENUES IN BALTIMORE
Fee for service: School Nurse Programs	Apply for Medicaid provider number as LHD or LEA for medically necessary services provided in schools e.g. IEP nurse services.	Used to retain positions cut in local funds budget, provide education benefits for nurses, purchase equipment, add clerical support
Health Related services IEP/IFSP	Application to Medicaid as provider reimbursement for services provided to school children under IEP/IFSP. School Districts can apply directly for provider status or enter into a Letter of Agreement with a local health department and provides services as a clinic of local health dept. Uses specific LHD provider number. Agencies described above apply to state Medicaid.	Produces a significant revenue base that can support entire SBHC programs as is done by Baltimore County. Baltimore's MOU between Health and Education stipulates that revenues must be used to expand or initiate expanded health services in schools. 38 school nurse positions, CHN Supvr, 6 Aides, social workers, 57 school-based mental health clinics, assistive technology equipment and a portable Dental Sealant Program for elementary schools.
Case Management for Pediatric AIDS	Have school or clinic nurse provide case management for HIV positive children in schools through cooperation with local Pediatric AIDS Coordinator.	New option in Maryland.
Home-based services & Service Coordination services	Apply for or include in MA provider application.	Not used in Baltimore schools.
Targeted Case Management under Healthy Start	Available for school nurses who complete required assessments and follow-up for eligible children.	Not used

Another way for SBHCs to minimize the amount of budgetary support that must be raised each year involves attracting community resources to help the center carry out its work.

> With respect to seeking grants, remember that government agencies and most private foundations currently are not looking to underwrite long-term service programs, such as SBHCs. Thus, a SBHC should think in terms of proposing 2-3 year demonstration projects that can contribute to the center's mental health focus but which are designed specifically to address a particular agency's or foundation's priorities (e.g., projects to reduce dropout, substance abuse, gang violence, suicide; projects related to models for integrating center, school, and community resources).
>
> Every major funding source will send, upon request, a statement of current priorities and application procedures.

A variety of helpful resources related to financial concerns are provided in one of the specially prepared packets designated as *Accompanying Resources*. This resource aid, entitled *Financial Strategies to Aid in Addressing Barriers to Learning*, is outlined in the last section of this guidebook.

In addition to major financial underwriting, school-based health centers can enhance their resources through outreach that attracts local support.

Volunteer staff. Centers can increase the range of services and minimize costs by supplementing paid staff with volunteers. Indeed, the only way some centers can provide a significant focus on mental health is by using volunteer professionals directly or to supervise volunteer or paid paraprofessionals and trainees.

Agencies. It is a given that centers need to connect with local agencies and organizations that provide counseling services (e.g., county mental health, substance abuse programs, youth groups). Similarly, community agencies and organizations can be convinced about the benefits of outreaching to the school in ways that result in additional services at the school. For example, county mental health workers are coming to some centers to provide services to students who qualify for but are unlikely to travel to county programs.

Advisory boards. Community and professional advisory boards often are mandated for centers. Whether mandated or not, such advisory groups can be encouraged to play a role in advocating for additional programs and support. In addition, some advisory board members can be mobilized to use their networks to help recruit volunteers.

Adopters/sponsors. Individuals, local businesses (including corporations housed in the area), service clubs and other organizations can be recruited as sponsors. The success of adopt-a-school programs suggests the potential of "adopt-our-center" campaigns. Sponsors can help meet specific resource needs ranging from donating center furnishings to financial contributions. Sponsors may or may not choose to participate on advisory boards.

Excerpts from an article by Alpha Center in *State Initiative's Newsletter* (October, 1995)

School-Based Health Centers Search for Funding: Eye Managed Care Organizations as Partners

With the growing of Medicaid managed care, school-based health centers have seen their reimbursement dollars drop at an alarming rate. In 1994 alone, the Baltimore City Health Department witnessed declines in Medicaid revenue of 35 percent for its school-based health centers as a result of managed care. During that same year, school-based health centers in the Bronx estimated a loss of $30,000 in Medicaid revenue for services they provided to managed care enrollees.

It is a trend that proponents of school-based health centers are watching with great trepidation. But it is also motivating administrators of these centers to negotiate with managed care plans in hopes of not only stanching the revenue bleeding, but possibly securing a steady source of funding. At the same time, a partnership with managed care plans would help place school-based health centers in the mainstream of health care delivery and improve care coordination for school-aged children.

The majority of students seen in school-based health centers are uninsured, with between 30 percent and 35 percent of the students on Medicaid. But as more states expand Medicaid coverage to uninsured children, that will ensure that a larger pool of children in high schools will receive coverage. At the same time, however, more and more states are enrolling their Medicaid populations into managed care plans. "If school-based health centers do not become part of that system, they will cease to exist," predicts Karen Hacker, of the Boston Department of Health and Hospitals.

Financial survival isn't the only reason for linking with managed care. According to Donna Zimmerman, executive director of Health Start, Inc. in St. Paul, Minnesota, and president of the new National Assembly on School-Based Health Care, the advantages are three-fold. First, negotiating with managed care organizations to reimburse services provided at school-based health centers will stop a backward slide in overall reimbursements. The new relationship will also ensure that students don't have "to be taken out of a system of care that they've become accustomed to," says Zimmerman. Furthermore, a large managed care organization has greater resources that could be used to assist clinics with quality improvement programs or staffing.

(cont.)

(continued from preceding page)

But partnering with managed care organizations is not easy. The barriers are many, ranging from having to prove a school-based center's effectiveness to negotiating an acceptable reimbursement rate and developing more sophisticated billing and information systems. "Nobody's going to contract with them just because they're the good guys," says Sandra Maislen of the Boston-based Neighborhood Health Plan.

. . . Maislen's network is investing in school-based health centers. Maislen says the network is interested in working with the centers because the state has established standards for school-based health centers to make certain a basic quality of service is provided. The Neighborhood Health Plan views the schools as well-equipped to reach a population that has traditionally shied away from services. Twenty-two of the network's health centers have links with designated school-based sites throughout Boston, paying a capitated rate that takes into account such things as violence prevention. And the network is in the process of opening up the system so that any network member can receive care at any school-based health center and the services will be reimbursed.

"We are where the patients are," says Zimmerman. For managed care organizations that must meet Medicaid mandates to screen a certain percentage of adolescents, school-based health centers are uniquely positioned to help them attain that goal. "We provide very good access to Medicaid patients for the health plans, and we have access to whole families by virtue of the children being in the schools," Zimmerman adds.

Besides, for some problems an adolescent is more likely to seek advice or care from a provider based in the school than a health plan doctor. "It's unlikely that a teenager is going to say to a parent 'I've got a vaginal discharge, do you think I need to be tested?'" offers Maislen.

Maislen suggests that school-based health centers have to start thinking more strategically, marketing specific programs to HMOs. In Boston, programs targeted at Asthma management, preventing motor vehicle accidents and stopping violence would go a long way, says Maislen. Such preventive programs can stop such traumatic incidents from happening, and the costs associated with these services are far less than those for treating accident and shooting victims.

Focusing on partnerships with managed care plans isn't the only key to survival. The centers need to seek out partnerships with state governments and other organizations to build a network of support. Centers also need to build relations with other groups of providers to secure their place as alternate sites of care for adolescents. While successful negotiations could lead to more Medicaid revenue, those reimbursements will never be enough to fully fund center operations. According to Zimmerman, school-based health centers will always have to search out alternate sources of funding.

Optimizing the Use of the Center's Mental Health Professional

Given: School-based health centers have very limited funds.

Given: School-based health centers vary in how much of their funds can be devoted to mental health staffing.

Assumption: A center probably can initiate a meaningful mental health focus with a 10 hour per week mental health professional.

Observation: A professional with only 10 hours a week who is assigned 10 hours of direct service can serve only a small percentage of students.

Question: **How can a 10 (20, 30 or more) hour per week mental health professional best respond to the volume of psychosocial problems at the school?**

Note: The term **mental health professional** is used to designate the wide variety of center personnel whose responsibility it is to plan and implement a center's mental health focus. Such personnel may be social workers, school or clinical psychologists, counselors; some are certificated in two fields (e.g., nursing and social work, social work and psychology). Each brings slightly different skills. However, whatever the individual's skills, s/he will be confronted with a need to expand them and to team with others in pursuit of a multifaceted and catalytic mental health focus.

Proposed Tasks for 10 Hours

The most potent use of a 10 hour per week mental health professional is for that individual to work primarily on specific aspects of 2 of the 3 areas of function outlined earlier. That is, most of the time should be devoted to functions related to coordination, development, and leadership to enhance use and efficacy of existing resources at the school and in the community. Direct service should be limited to 1-2 hours.

In particular, with a specific focus on mental health and psychosocial concerns, the mental health professional should play a *catalytic role* in

***Mapping and Analyzing Existing Resources and Systems**

Examples of relevant tasks are working with others at the school to

- clarify and publicize resources for intervention and referral on and off campus
- improve existing systems for problem identification and referral, case management, crisis response, and so forth so that any student with a problem is referred to appropriate on-campus services -- or off-campus if necessary
- reduce redundancy and problems resulting from fragmented approaches
- develop ideas for using resources in a more cost-effective manner

***Enhancing Connections and Coordination Among Resources**

Examples of relevant tasks are working with others at the school and in the community to

- facilitate coordination, integration, sharing, and problem solving
    - >in the center
    - >between the center and school
    - >with community resources
    - >with other school-based health centers and sources for technical assistance
- enhance working relationships among relevant people, programs, and agencies on and off campus by helping establish and maintain mechanisms for coordination, communication, and problem solving

***Enhancing Resources**

Examples of relevant tasks are working with others at the school and in the community to

- identify, recruit, and supervise interns, trainees, and volunteers to provide direct mental health services at the center
- identify and develop added resources to enhance campus programs

Added Tasks for a 20 Hour Week

Beside the above functions, with an additional 10 hours a week, time can be devoted to tasks involved in

***increasing the amount of direct service impact through consultation, training, and supervision**

Examples of relevant tasks are working with

- center staff on the implications of emotional aspects of physical conditions
- school staff on the implications of mental health and psychosocial concerns related to types of problems and specific students

***development of and involvement in programmatic approaches to enhance direct services and instruction**

Examples of relevant tasks are working with others at the school and in the community to enhance programs for

- Crisis intervention and emergency assistance (e.g., psychological first-aid and follow-up; suicide prevention; emergency services, such as food, clothing, transportation)
- Assessment (individuals, groups, classroom, school, and home environments)
- Treatment, remediation, rehabilitation (incl. secondary prevention)
- Accommodations to allow for differences and disabilities
- Transition and follow-up (e.g., orientations, social support for newcomers, follow-thru)
- Primary prevention through protection, mediation, promoting and fostering opportunities, positive development, and wellness (e.g., guidance counseling; contributing to development and implementation of health and violence reduction curricula; placement assistance; advocacy; liaison between school and home; gang, delinquency, and safe-school programs; conflict resolution; prevention-oriented information and discussion with students in classrooms and for school staff, parent groups, and community organizations)

30 or More Hours

Beside expanding activity with respect to all the preceding functions, a significant proportion of the additional 10-20 hours can be devoted to supplementing **direct intervention** (e.g., assessing specific student needs, formal and informal counseling, crisis intervention, case coordination, home visits, referrals, follow-up evaluations).

Starting from Zero

Some centers cannot afford to hire a mental health professional. The first steps in such circumstances are

- to increase the ability of center staff to cope with difficult to handle students
- to develop sound procedures for referring students to appropriate mental health services on- and off-campus.

Another relatively easy step in initiating a mental health focus is to train staff to include an emphasis on mental health as part of all health education activity. These steps can be accomplished through inservice training and consultation provided to center staff by knowledgeable school district and/or community professionals.

A somewhat more difficult, but feasible strategy is to build a multifaceted mental health focus using volunteers. For example, one or two professionals can be recruited to assume organizational and supervisory roles (see proposed tasks for 10 hours); others can be recruited to provide direct services and the other functions outlined.

Staffing School-Based Health Centers

In addressing the topic of staffing patterns for school-based health centers, a national work group* recommended the following:

For every 700 enrolled students, there should be
1.0 FTE nurse practitioner or physician assistant
0.1-0.5 FTE physician
1.5 FTE mental health counselor
1.0 FTE health educator
0.5 FTE health assistant
0.5 FTE program manager.

As support for this level of staffing, the report states:

> *Development of these staffing ratios is seen as analogous to those is use by health maintenance organizations to ensure adequate capacity and cost effectiveness.*

The report further states that

> *The multi-disciplinary staff required for comprehensive service delivery could be derived from a combination of school-based health center staff under the sponsorship of a local health care provider; staff from community agencies that are linked to or co-located at the school; and school personnel. The involvement of school personnel such as school nurses, school psychologists, social workers, and substance abuse counselors was seen as critical to efficient and effective comprehensive service delivery.*

*C. Brellochs, K. Fothergill, et al. (1995). *Ingredients for success: Comprehensive school-based health centers: A special report on the 1993 national work group meetings.* NY: School Health Policy Initiative.

BEST COPY AVAILABLE

RESOURCE AIDS

A. Resource Aid Included Here

Resource Aid IA-1

Examples of Federal Resources

Table illustrating the range of federally supported programs which exist to meet specific needs of children and young adults with disabilities.

B. Related Resource Aid Packet Available from Our Center

Financial Strategies to Aid in Addressing Barriers to Learning

Designed as an aid in conceptualizing financing efforts, identifying sources, and understanding strategies related to needed reforms.

Examples of Federal Resources

To illustrate the range of federally funded resources, the following information was abstracted from "Special Education for Students with Disabilities" (1996) in *The Future of Children*, 6, 162-173. The document's appendix provides a more comprehensive table.

Highlighted is a broad range of federally supported programs which exist to meet specific needs of children and young adults with disabilities. Services include education, early intervention, health services, social services, income maintenance, housing, employment, and advocacy. Included here is information about programs that

- are federally supported (in whole or in part)
- exclusively serve individuals with disabilities or are broader programs (for example, Head Start) which include either a set-aside amount or mandated services for individuals with disabilities.
- provide services for children with disabilities or for young adults with disabilities through the process of becoming independent, including school-to-work transition and housing
- have an annual federal budget over $500,000,000 per year. (Selected smaller programs are also included).

Category	Program	Purpose	Target Population	Services Funded
Education	Special Education-State Grants Program for Children with Disabilities US Dept. of Education, Office of Special Education Programs contact: Division of Assistance to States, (202) 205-8825	To ensure that all children with disabilities receive a free, appropriate public education (FAPE). This is an entitlement program	Children who have one or more of the following disabilities and who need special education or related services: Mental retardation, Hearing impairment, Deafness, Speech or language impairment, Visual impairment, Serious emotional disturbance, Orthopedic impairments, Autism, Traumatic brain injury, Specific learning disabilities, Other health impairments	Replacement evaluation, Reevaluation at least once every 3 years, Individualized education program, Appropriate instruction in the least restrictive environment
Comprehensive Services to Preschool Children	Head Start US Dept. of Health and Human Services contact: Head Start Bureau, (202) 205-8572	To provide a comprehensive-array of services and support which help low-income parents promote each child's development of social competence	Primarily 3- and 4-year-old low-income children and their families Statutory set-aside requires that at least 10% of Head Start enrollees must be disabled children	Education, Nutrition, Dental, Health, Mental health, Counseling/psychological therapy, Occupational/physical/speech therapy, Special services for children with disabilities, Social services for the family
Health	Medicaid US Dept. of Health and Human Services contact: Medicaid Bureau, (410) 768-0780	To provide comprehensive health care services for low-income persons This is an entitlement program	Low-income persons: Over 65 years of age, Children and youths to age 21, Pregnant women, Blind or disabled, and in some states-Medically needy persons not meeting income eligibility criteria	Screening, diagnosis, and treatment for infants, children, and youths under 21; Education-related health services to disabled students; Physician and nurse practitioner services; Rural health clinics; Medical, surgical, and dental services; laboratory and x-ray services; nursing facilities and home health for age 21 and older; Home/community services to avoid institutionalization; family plan-ning services and supplies.
Health	Disabilities Prevention US Dept. of Health and Human Services, Centers for Disease Control and Prevention contact: Disabilities Prevention Program, (770) 488-7082	Funds educational efforts and epidemiological projects to prevent primary and secondary disabilities	Persons with: Mental retardation, Fetal alcohol syndrome, Head and spinal cord injuries, Secondary conditions in addition to identified disabilities, Selected adult chronic conditions	Funds pilot projects that are evaluated for effectiveness at disability prevention; Establishes state offices and advisory bodies; Supports state/local surveillance and prevention activities; Conducts and quantifies prevention programs; Conducts public education/aware-ness campaigns

Category	Program	Purpose	Target Population	Services Funded
Health	Maternal and Child Health Services US Dept. of Health and Human Services contact: Maternal and Child Health Bureau, (301)443-8041	To provide core public health functions to improve the health of mothers and children	Low-income women and children; Children with special health needs, including but not limited to disabilities	Comprehensive health and related services for children /with special health care needs; Basic health services including preventative screenings, prenatal and postpartum care, delivery, nutrition, immunization, drugs, laboratory tests, and dental; Enabling services including transportation, case management, home visiting, translation services
Mental Health	Comprehensive Mental Health Services for Children and Adolescents with Serious Emotional Disturbances and Their Families US Dept. of Health and Human Service contact: Child, Adolescent and Family Branch Program Office, (301) 433-1333	The development of collaborative community-based mental health service delivery systems	Children and adolescents under 22 years of age with severe emotional, behavioral, or mental disorders and their families	Diagnostic and evaluation services; Individualized service plan with designed case manager; Respite care; Intensive day treatment; Therapeutic foster care; Intensive home-, school-, or clinic-based services; Crisis services; Transition services from adolescence to adulthood
Social Services	Foster Care US Dept. of Health and Human Services contact: Children's Bureau, (2020) 205-8618	To assist states with the costs of: foster care maintenance; administrative costs; training for staff, foster parents, and private agency staff. This is an entitlement program	Children and youths under 18 who need placement outside their homes	Direct costs of foster care maintenance; placement; case planning and review; training for staff, parents, and private agency staff
Housing	Supportive Housing US Dept. of Hosing and Urban Development (HUD contact: Local Housing and Urban Development field office	To expand the supply of housing that enables persons with disabilities to live independently	Very low-income persons who are: blind or disabled, including children and youths 18 years of age and younger who have a medically determinable physical or mental impairment and who meet financial eligibility requirements; over 65 years of age	Cash assistance Average monthly payment is $420 per child with disability. Range is from $1 to $446

UNIT IB: INTEGRATED ACTIVITY TO MAXIMIZE RESOURCE USE AND EFFECTIVENESS

Contents

Page

- Working Together with School and Community IB-1

    >Phases of Collaboration IB-2
        Integrating with the Center IB-2
        Integration of Health Center into the School IB-3
        Outreach and Networking Outside the School IB-3
    >Phases of Health Center Integration, Outreach, and Networking IB-4
    >Working Together with Others to Enhance Programs and Resources IB-5
    >It's Not Just About Collaboration -- It's About Being Effective IB-5
        A team to manage care IB-10
        A team to manage resources IB-12
    >Fully Integrating with School and Community Resources IB-15

- Overcoming Barriers to Working Together IB-17

    >Differences as a Problem IB-17
    >Differences as a Barrier IB-18
    >Overcoming Barriers Related to Differences IB-20
    >Building Rapport and Connection IB-21

- One Other Observation IB-24

Coda: Enhancing Available Resources IB-25

Resource Aids IB-27

A Few Related References IB-62

Exhibits and Resource Aids in Unit IB

Exhibits

Unit IB *Page*

7. Some General Guidelines for Establishing School Site Collaborative Teams IB-7

8. Planning and Facilitating Effective Meetings IB-8

9. Accounting for Cultural, Racial, and Other Significant Individual and Group Differences IB-22

Resource Aids

Unit IB

IB-1. Survey Instruments to Aid in Mapping and Analyzing Existing School-Based/Linked Psychosocial and Mental Health Systems, Programs, and Services IB-29

IB-2 Developing a Resource Coordinating Team IB-58

IB-3 Developing a Complex (Multisite) Resource Coordinating Council IB-60

Unit IB
Integrated Activity to Maximize Resource Use and Effectiveness

One of the most productive, potent, and sustainable ways a SBHC can maximize its resources and intervention effectiveness is to fully integrate its efforts within the Center, with other school programs, and with community efforts.

> Such integration will not occur spontaneously. It requires ongoing efforts to develop effective working relationships and collaborative activity.

Working Together with School and Community

The school's principal and a staff member from the School-Based Health Center passed each other in the hall. Suddenly, the principal whirled around and with a rather sharp tone said:

> *You folks should try to remember this is a school with a health center, not a health center with a school!*

The incident underscores the necessity of center staff working diligently to be seen as an integral part of a school--not as an outsider.

In effect, center staff must consistently be working toward (1) integration of their internal activity (medical, mental health, health education); (2) integration with other programs and services at a school; and (3) integration with community resources. These can be viewed in terms of phases of collaboration.

Working Together?

Two best friends were taking a walk in the woods when they saw a giant grizzly bear approaching them, erect, claws bared. Being the best of friends, they clung to one another for dear life. But then one of the two disengaged, knelt to unlace his hiking boots, and hurriedly put on his running shoes.

I don't get it, his best friend said. *What can you hope to achieve? You and I both know there's no way you can outrun a grizzly bear.*

Silly, said his friend, *I don't have to outrun the bear. I only have to outrun you.*

Phases of Collaboration

I. Integrating within the Center

Meeting the needs of adolescents using school-based Centers requires a blending of physical and mental health expertise. In the center, this is accomplished through integration of physical and mental health and health education activity in ways that encourage teamwork. That is, working in an integrated manner involves a partnership among all center staff (e.g., clerical, medical, mental health, and health education personnel).

> At its core, the partnership encompasses a close working relationship around initial contacts, triage and other assessment tasks, referrals for counseling, health education, programming, and handling crises and problems. Such teamwork is seen as essential in maximizing center effectiveness which, in turn, should increase a staff's sense of accomplishment and counter "burn-out."

Following are five activities that mental health staff can pursue to improve integration of the mental health focus within the center.

1. *Interact daily with other center staff around clients' interviews, problems, and crises.* It is productive to have a mental health person reserve part of the day to handle special problems, consult about client needs, and meet immediately with students who raise mental health concerns. As a result of daily staff interactions, other center staff learn how to identify psychosocial problems, when and where to refer, and how to deal more effectively with student affect.

2. *Participate in weekly reviews of initial contacts -- with mental health concerns a significant part of the agenda.* Weekly reviews allow for discussion of problems that may be psychosomatic (e.g., related to anxiety, loss, depression) and what kinds of support seem most beneficial.

3. *Offer staff development.* Most staff appreciate additional training and support for working with students who are in crisis, distraught, threatening, or manipulative, or who have serious/chronic medical problems.

4. *Work with health educator.* The scope and potential impact of health education programs are increased when a center expands its focus to include a holistic orientation and offers specific presentations on such psychosocial concerns at suicide, depression, aftereffects of abuse, trauma, loss.

5. *Involve entire center staff in case discussions and periodic reviews of ongoing counseling.* Mental health case conferences allow other staff to offer ideas, learn more about psychosocial problems, and become aware of what can and cannot be accomplished through counseling.

II. Integration of Health Center into the School

The way to improve mental health services for all students in the school is through

- coordination and integration among all programs at the school
- expanding the range of intervention options

These objectives are only possible through establishment of a close working relationship with school staff who are responsible for and interested in psychosocial programs. A key procedure in stimulating such integration is a Resource Coordinating Team (discussed later). Another approach is to identify ongoing programs and then establish personal working relationships with the staff involved. In either case, it is helpful to have an official school administrative liaison to the center who is supportive and has positive influence with key school staff members.

III. Outreach and Networking Outside the School

Outreach to school district personnel and resources

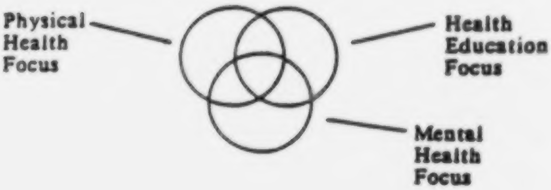
- identify key representatives of district-wide units responsible for psychosocial programs
- invite them to attend a school-wide Resource Coordinating Team meeting
- establish personal working relationships where appropriate

One way to think about the integration, outreach, and networking is in terms of a center's phases of development. While a center deals with all these matters from the day it opens, the first major concern is with integration within the center. As this task is accomplished, more energy can be devoted to the task of integrating the center within the school. And eventually, the task is to improve outreach and networking outside the school, with school district personnel and programs, with the community, and with other centers (locally, regionally, nationally).

> Outreach and resource networking activities beyond the school are not easy to undertake or maintain. Such activity requires establishing lines of communication and developing working relationships. And, as in any relationship, there are benefits and costs.
>
> Among the benefits are the opportunity to learn about how others handle the problems you're trying to solve, share ideas for new programs and practices, and establish mutual support mechanisms for training and consultation.
>
> Among the costs are the time it takes to meet with others -- (after all, who doesn't already have a full schedule?) and the effort it takes to learn to work productively with another set of professionals.
>
> Appropriately handled, the benefits of outreach and networking far outweigh the costs.

Phases of Health Center Integration, Outreach, and Networking

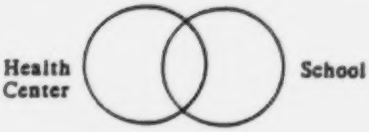
Phase I: Integration within the Health Center:



Integrated & coordinated services can improve

1. triage and treatment of both physical & Psychosocial problems
2. staff develop. & mutual support
3. health education (by focusing on physical & psychosocial concerns)
4. handling of crises & distraught, threatening, or manipulative students
5. center effectiveness & staff sense of fulfillment (thus countering Burn-out)

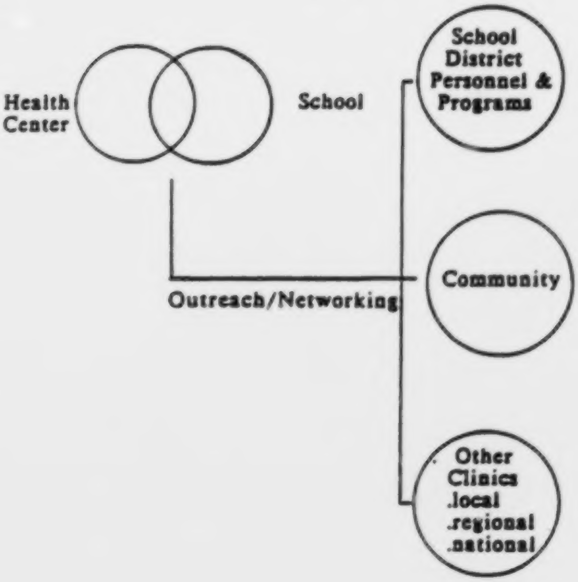
Phase II: Integration of Health Center Within the School



Integration & coordination of center and school programs can increase

1. awareness of and access to appropriate on-site center and school referrals
2. coordination with other school programs working on a student's problems
3. development of additional school programs focused on clients' specific needs
4. understanding of respective roles & functions and productive sharing of expertise
5. efficacy of intervention & staff sense of accomplishment

Phase III: Outreach and Networking Outside the School


Health Center
School
Outreach/Networking
School District Personnel & Programs
Community
Other Clinics .local .regional .national

Outreach & Networking can result in

1. attracting additional programs to the campus
2. adoption/adaptation of additional programs identified as needed
3. ready access to extra support and expertise with respect to difficult problems and crises
4. awareness of and access to appropriate off-site referrals
5. coordination with other off-site programs working on a student's problems
6. useful sharing of policies, ideas, and problem solutions
7. evolving to a systems orientation with comprehensive, integrated approaches

Working Together with Others to Enhance Programs and Resources

"We're still rather isolated from the rest of the school."

"We don't know much about the other programs at the school."

"The school had a workshop on suicide prevention last week, and we just heard about it."

It is sometimes hard for a school-based health center to integrate into a school and work in a coordinated way with other school programs if there is no common meeting ground. Community and professional advisory groups can help; school-based working groups are essential.

> For programs at the school to improve, there must be both individual and group efforts. Group efforts may focus on planning, implementation, evaluation, advocacy, and involvement in shared decision making related to policy and resource deployment. In working together to enhance existing programs, group members look for ways to improve communication, cooperation, coordination, and integration within and among programs. Through such collaborative efforts, they can (a) enhance program availability, access, and management of care, (b) reduce waste from fragmentation and redundancy, (c) redeploy the resources saved, and (d) improve program results.

Formal opportunities for working together at schools often take the form of committees or councils and teams. To be effective, such collaborative efforts require thoughtful and skillful facilitation. Without careful planning and implementation, collaborative efforts rarely can live up to the initial hope. Even when they begin with great enthusiasm, poorly facilitated working sessions quickly degenerate into another ho-hum meeting, more talk but little action, another burden, and a waste of time. This is particularly likely to happen when the emphasis is mainly on the unfocused mandate to "collaborate," rather than on moving an important vision and mission forward through effective working relationships.

It's Not Just About Collaboration – It's About Being Effective

Most of us know how hard it is to work effectively with a group. Many staff members at a school site have jobs that allow them to carry out their duties each day in relative isolation of other staff. And despite various frustrations they encounter in doing so, they can see little to be gained through joining up with others. In fact, they often can point to many committees and teams that drained their time and energy to little avail.

Despite all this, the fact remains that no organization can be truly effective if everyone works in isolation. And it is a simple truth that there is no way for schools to play their role in addressing barriers to student learning and enhancing healthy development if a critical mass of stakeholders do not work together towards a shared vision. There are policies to advocate for, decisions to make, problems to solve, and interventions to plan, implement, and evaluate.

> Obviously, true collaboration involves more than meeting and talking. The point is to work together in ways that produce the type of actions that result in effective programs. For this to happen, steps must be taken to ensure that committees, councils, and teams are formed in ways that ensure they can be effective. This includes providing them with the training, time, support, and authority to carry out their role and functions (see Exhibits 7 and 8). It is when such matters are ignored that groups find themselves meeting and meeting, but going nowhere.

There are many committees and teams that those concerned with addressing barriers to learning and promoting healthy development can and should be part of. These include school-site shared decision making bodies, committees that plan programs, teams that review students referred because of problems and that manage care, quality review bodies, and program management teams.

> Two key teams are highlighted here because of the essential role they play in enhancing program effectiveness: (1) a team to manage client care and (2) a team to manage program and service resources.

Some wag defined collaboration as
an unnatural act between nonconsenting adults.

Exhibit 7: Some General Guidelines for Establishing School-Site Collaborative Teams

Two basic problems in forming collaborative teams at school-sites are (a) identifying and deploying committed and able personnel and (b) establishing an organizational structure that provides sufficient time and nurtures the competence and commitment of team members. The following are some suggestions that can help in dealing with these problems.

1. For staff, job descriptions and evaluations must reflect a policy that personnel are expected to work in a coordinated and increasingly integrated way with the aim of maximizing resource use and enhancing effectiveness.

2. To maximize resource coordination and enhancement at a school, every staff member must be encouraged to participate on some team designed to improve students' classroom functioning. The importance of such teams should be recognized through provision of time and resources that allow team members to build capacity and work effectively together.

3. Teams may consist of current resource staff, special project staff, teachers, site administrators, parents, older students, and others from the community. In this last regard, representatives of school-linked community services must be included. Individuals should be encouraged to choose a team whose work interests them.

4. Group should vary in size -- from two to as many as are needed and interested. Major criteria used in determining size should be factors associated with efficient and effective functioning. The larger the group, the harder it is to find a meeting time and the longer each meeting tends to run. Frequency of meetings depends on the group's functions, time availability, and ambitions. Properly designed and trained teams can accomplish a great deal through informal communication and short meetings.

5. The core of a team is staff who have or will acquire the ability to carry out identified functions and make the mechanism work; others can be auxiliary members. All should be committed to the team's mission. Building team commitment and competence should be one major focus of school management policies and programs.

6. Because several teams require the expertise of the same staff (nurse, psychologist, counselor, resource teacher, social worker, administrator, teacher, parent), these individuals will necessarily be on more than one team.

7. Each team needs a dedicated leader/facilitator who has the ability to keep the group task-focused and productive and someone who records decisions and plans and reminds members of planned activity and products.

8. Team functioning is enhanced through use of computer technology (management systems, electronic bulletin boards and email, resource clearinghouses). Such technology facilitates communication, networking, program planning and implementation, linking activity, and a variety of budgeting, scheduling, and other management concerns.

9. Effective teams should be able to produce savings in terms of time and resources through appropriately addressing their areas of focus. In addition, by tapping into public health-care funds, a district may be able to underwrite some of the costs of those team members who also provide specific services.

Exhibit 8: Planning and Facilitating Effective Meetings

There are many fine resources that provide guidelines for conducting effective meetings. Some key points are synthesized below.

Forming a Working Group

- There should be a clear statement about the group's mission.
- Be certain that the members agree to pursue the stated mission and, for the most part, share a vision.
- Pick someone who the group will respect and who either already has good facilitation skills or will commit to learning those that are needed.
- Provide training for members so they understand their role in keeping a meeting on track and turning talk into effective action.
- Be certain to designate processes (a) for sending members information before a meeting regarding what is to be accomplished, specific agenda items, and individual assignments and (b) for maintaining and circulating a record of decisions and planned actions (what, who, when) formulated at the meeting.

Meeting Format

- Be certain there is a written agenda and that it clearly states the purpose of the meeting, specific topics, and desired outcomes for the session.
- Begin the meeting by reviewing purpose, topics, desired outcomes, etc. Until the group is functioning well, it may be necessary to review meeting ground rules.
- Facilitate the involvement of all members, and do so in ways that encourage them to focus specifically on the task. The facilitator remains neutral in discussion of issues.
- Try to maintain a comfortable pace (neither too rushed, nor too slow; try to start on time and end on time -- but don't be a slave to the clock).
- Periodically review what has been accomplished and move on to the next item.
- Leave time to sum up and celebrate accomplishment of outcomes and end by enumerating specific follow-up activity (what, who, when). End with a plan for the next meeting (date, time, tentative agenda). For a series of meetings, set the dates well in advance so members can plan their calendars.

(cont.)

Exhibit 8 :(cont.) **Planning and Facilitating Effective Meetings**

Some Group Dynamics to Anticipate

Despite the best of intentions, group members sometimes find it difficult to stay on task. Some of the reasons are

Hidden Agendas -- A person may feel compelled to make some point that is not on the agenda. At any meeting, there may be a number of these hidden agenda items. There is no good way to deal with these. It is important that all members understand that hidden agendas are a problem, and there should be agreement that each member will take responsibility for keeping such items in check. However, there will be times when there is little choice other than to facilitate the rapid presentation of a point and indicate where the concern needs to be redirected.

A Need for Validation -- Even when people are task-focused, they may seem to be making the same point over and over. This usually is an indication that they feel it is an important point but no one seems to be accounting for it. To counter such disruptive repetition and related problems, it is helpful to use flipcharts or a writing board on which group member points are highlighted (hopefully with some form of organization to enhance coherence and facilitate summarizing). Accounting for what is said in this visible way helps members feel their contributions have been heard and validated. It also allows the facilitator to point to a matter as a visible reminder to a member that it has already been raised. When a matter is one that warrants discussion at a later time, it can be assigned to a future agenda or planning list to be addressed if time allows toward the end of the meeting or at a subsequent meeting.

Members are at an Impasse -- Two major reasons groups get stuck are: (a) some new ideas are needed to "get out of a box" and (b) differences in perspective need to be aired and resolved. The former problem usually can be dealt with through brainstorming or by bringing in someone who has some new alternatives to offer. The latter problem involves conflicts that arise over process, content, and power relationships and is dealt with through problem solving and conflict management strategies (e.g., accommodation, negotiation, mediation).

Interpersonal Conflict and Inappropriate Competition -- Some people find it hard to like each other or feel compelled to show others up. Sometimes the problem can be corrected by repeatedly bringing the focus back to the goal -- improving outcomes for students/families. Sometimes, however, the dislike or competitiveness is so strong that certain individuals simply can't work closely together. If there is no mechanism to help minimize such interpersonal dynamics, the group needs to find a way to restructure its membership.

Ain't It Awful! -- The many daily frustrations experienced by staff members each day often lead them to turn meetings into gripe sessions. One of the benefits of including parents and community members (agency staff, business and/or university partners) is that, like having company come to one's home, outside team members can influence school staff to exhibit their best behavior.

Two References

Rees, F. (1993). *25 Activities for Teams.* San Diego CA: Pfeiffer & Co.

Brilhart, J.K. & Galanes, G.J. (1995). *Effective Group Discussion* (8th ed.). Madison, WI: WCB Brown & Benchmark.

A Team to Manage Care

When a client is involved with more than one intervener, management of care becomes a concern. This clearly is always the situation when a student is referred for help over and above that which her/his teacher(s) can provide. Subsequent monitoring as part of the ongoing management of client care focuses on coordinating interventions, improving quality of care (including revising intervention plans as appropriate), and enhancing cost-efficacy.

> Management of care involves a variety of activity all of which is designed to ensure that client interests are well-served. At the core of the process is enhanced monitoring of care with a specific focus on the appropriateness of the chosen interventions, adequacy of client involvement, appropriateness of intervention planning and implementation, and progress. Such ongoing monitoring requires systems for
>
> - tracking client involvement in interventions
> - amassing and analyzing data on intervention planning and implementation
> - amassing and analyzing progress data
> - recommending changes

Effective monitoring depends on information systems that enable those involved with clients to regularly gather, store, and retrieve data. Schools rely heavily on forms for gathering necessary information (see Module II). In coming years, more and more of this information will be entered into computers to facilitate retrieval and assist in other ways with client care.

> Management of care, of course, involves more than monitoring processes and outcomes. Management also calls for the ability to produce changes as necessary. Sometimes steps must be taken to improve the quality of processes, including at times enhancing coordination among several interveners. Sometimes intervention plans need to be revised to increase their efficacy and minimize their "costs" -- including addressing negative "side effects." Thus, management of care involves using the findings from ongoing monitoring to clarify if interventions need to be altered and then implements strategies to identify appropriate changes and ensure they are implemented with continued monitoring. Along the way, those involved in managing the client's care may have to advocate for and broker essential help and provide the linkage among services that ensures they are coordinated. They also must enhance coordinated intervener communication with the student's care givers at home.

Who does all this monitoring and management of care? Ideally, all involved parties -- interveners and clients -- assume these functions and become the *management team.* One member of such a team needs to take *primary* responsibility for management of care (a *primary manager*). Sites with sufficient resources often opt to employ one staff member to fill this role for all clients. However, given the limited resources available to schools, a more practical model is to train many staff to share such a role. Ultimately, with proper instruction, one or more family members might be able to assume this role.

> All who become primary managers of care must approach the role in a way that respects the client and conveys a sense of caring. The process should be oriented to problem-solving but should not be limited to problem treatments (e.g., in working on their problems, young people should not be cut off from developmental and enrichment opportunities). In most instances, a youngster's family will be integrally involved and empowered as partners, as well as recipients of care. Well-implemented management of care can help ensure that clients are helped in a comprehensive, integrated manner designed to address the whole person. A positive side effect of all this can be enhancement of systems of care.

Management teams should meet whenever analysis of monitoring information suggests a need for program changes and at designated review periods. Between meetings, it is the responsibility of the primary manager to ensure that care is appropriately monitored, team meetings are called as changes are needed, and that changes are implemented. It is the team as a whole, however, that has responsibility for designating necessary changes and working to ensure the changes are made.

The following list itemizes a few basic tasks for primary managers of care:

- Before a team meeting, write up analyses of monitoring data and any recommendations to share with management team.
- Immediately after a team meeting, write up and circulate changes proposed by management team and emphasize who has agreed to do which tasks and when.
- Set-up a "tickler" system to remind you when to check on whether tasks have been accomplished.
- Follow-up with team members who have not accomplished agreed upon tasks to see what assistance they need.

A Team to Manage Resources

School practitioners are realizing that since they can't work any harder, they must work smarter. For some, this translates into new strategies for coordinating, integrating, and redeploying resources. Such efforts start with new (a) processes for mapping and matching resources and needs and (b) mechanisms for resource coordination and enhancement.

> An example of a mechanism designed to reduce fragmentation and enhance resource availability and use (with a view to enhancing cost-efficacy) is seen in the concept of a *resource coordinating team*. Creation of such a school-based team provides a vehicle for building working relationships and a good mechanism for starting to weave together existing school and community resources and encourage services and programs to function in an increasingly cohesive way.

Where such a team is created, it can be instrumental in integrating the center into the school's ongoing life. The team solves turf and operational problems, develops plans to ensure availability of a coordinated set of services, and generally improves the school's focus on mental health.

Because of its potential value to school-based centers, it is well worth staff time to help a school establish such a team. In doing so, the center's mental health professional can play a catalytic role in starting the process by

1. surveying key school staff members to identify and map existing school-based psychosocial programs and who runs them

2. inviting key people from each program to a meeting with relevant center staff to discuss how various center, school, and community programs interface with each other (Note: Be certain to include the person designated by the school as the official liaison to the center, as well as any other school personnel who might be supportive and interested in program enhancement.)

At the first meeting,

3. if the programs are not coordinated, discuss ways to work together; if they do coordinate with each other, discuss how to integrate center mental health programs into the process

4. suggest the idea that the group constitute itself as a coordinating team and meet regularly (e.g., initially, every two weeks, then once a month)

For subsequent meetings,

5. act as facilitator (e.g., send out reminders about agenda, times, and places, circulate "minutes" after each meeting, help to ensure the meeting runs smoothly).

Once the team is established, it will raise concerns and ideas that require more time and follow-through than is possible during the meeting. To minimize frustration and maximize effectiveness,

6. set up a small subcommittee (e.g., the center mental health professional and 1-2 other team members) which will take time between meetings to work out details of ideas, work on solving some of the problems raised, and report back to the team.

Among the topics a coordinating team might address are ways to deal with crises and how to resolve dilemmas regarding consent, confidentiality, legal reporting requirements, and school district policies.

A resource coordinating team differs from teams created to review individual students (such as a student study team, a teacher assistance team, a case management team). That is, its focus is not on specific cases, but on clarifying resources and their best use. In doing so, it provides what often is a missing mechanism for managing and enhancing *systems* to coordinate, integrate, and strengthen interventions. For example, this type of mechanism can be used to weave together the eight components of school health programs to better address such problems as on-campus violence, substance abuse, depression, and eating disorders. Such a team can be assigned responsibility for (a) mapping and analyzing activity and resources with a view to improving coordination, (b) ensuring there are effective systems for referral, case management, and quality assurance, (c) guaranteeing appropriate procedures for effective management of programs and information and for communication among school staff and with the home, and (d) exploring ways to redeploy and enhance resources -- such as clarifying which activities are nonproductive and suggesting better uses for the resources, as well as reaching out to connect with additional resources in the school district and community.

Mapping Resources

The literature on resource coordination makes it clear that a first step in countering fragmentation involves "mapping" resources by identifying what exists at a site (e.g., enumerating programs and services that are in place to support students, families, and staff; outlining referral and case management procedures). A comprehensive form of "needs assessment" is generated as resource mapping is paired with surveys of the unmet needs of students, their families, and school staff.

Based on analyses of what is available, effective, and needed, strategies can be formulated for resource enhancement. These focus on (a) outreach to link with additional resources at other schools, district sites, and in the community and (b) better ways to use existing resources. (The process of outreach to community agencies is made easier where there is policy and organization supporting school-community collaboration. However, actual establishment of formal connections remains complex and is becoming more difficult as publicly-funded community resources dwindle.)

Perhaps the most valuable aspect of mapping and analyzing resources is that the products provide a sound basis for improving cost-effectiveness. In schools and community agencies, there is acknowledged redundancy stemming from ill-conceived policies and lack of coordination. These facts do not translate into evidence that there are pools of unneeded personnel; they simply suggest there are resources that can be used in different ways to address unmet needs. Given that additional funding for reform is hard to come by, such redeployment of resources is the primary answer to the ubiquitous question: *Where will we find the funds?*

See Resource Aid IB-1 for a set of surveys designed to guide mapping of existing school-based and linked psychosocial and mental health programs and services.

Although a resource coordinating team might be created solely around psychosocial programs, such a mechanism is meant to bring together representatives of all major programs and services supporting a school's instructional component (e.g., guidance counselors, school psychologists, nurses, social workers, attendance and dropout counselors, health educators, special education staff, bilingual and Title I program coordinators). This includes representatives of any community agency that is significantly involved at the school. It also includes the energies and expertise of one of the site's administrators, regular classroom teachers, non-certificated staff, parents, and older students. Where creation of "another team" is seen as a burden, existing teams can be asked to broaden their scope. Teams that already have a core of relevant expertise, such as student study teams, teacher assistance teams, and school crisis teams, have demonstrated the ability to extend their functions to encompass resource coordination. To do so, however, they must take great care to structure their agenda so that sufficient time is devoted to the additional tasks.

Properly constituted, trained, and supported, a resource coordinating team can complement the work of the site's governance body through providing on-site overview, leadership, and advocacy for all activity aimed at addressing barriers to learning and enhancing healthy development. Having at least one representative from the resource coordinating team on the school's governing and planning bodies helps ensure that essential programs and services are maintained, improved, and increasingly integrated with classroom instruction (see Resource Aid IB-2).

Local Schools Working Together

To facilitate resource coordination and enhancement among a complex of schools (e.g., a high school and its feeder middle and elementary schools), a resource coordinating *council* can be established by bringing together representatives of each school's resource coordinating *team*. Such a complex of schools needs to work together because in many cases they are concerned with the same families (e.g., a family often has children at each level of schooling). Moreover, schools in a given locale try to establish linkages with the same community resources. A coordinating council for a complex of schools provides a mechanism to help ensure cohesive and equitable deployment of such resources.

Fully Integrating with School and Community Resources

Most schools and many community services use weak models in addressing barriers to learning. The primary emphasis in too many instances is to refer individuals to specific professionals, and this usually results in narrow and piecemeal approaches to complex problems, many of which find their roots in a student's environment. Overreliance on referrals to professionals also inevitably overwhelms limited, public-funded resources.

BEST COPY AVAILABLE

More ideal models emphasize the need for a comprehensive continuum of community and school interventions to ameliorate complex problems. Such a continuum ranges from programs for primary prevention and early-age intervention -- through those to treat problems soon after onset -- to treatments for severe and chronic problems. Thus, they emphasize that promoting healthy development and positive functioning are one of the best ways to prevent many problems, and they also address specific problems experienced by youth and their families.

> Limited efficacy seems inevitable as long as the full continuum of necessary programs is unavailable; limited cost effectiveness seems inevitable as long as related interventions are carried out in isolation of each other. Given all this, it is not surprising that many in the field doubt that major breakthroughs can occur without a comprehensive and integrated programmatic thrust. Such views have added impetus to major initiatives designed to restructure community health and human services and the way schools operate.

To be most effective, such interventions are developmentally-oriented (i.e., beginning before birth and progressing through each level of schooling and beyond) and offer a range of activity -- some focused on individuals and some on environmental systems. Included are programs designed to promote and maintain safety at home and at school, programs to promote and maintain physical/mental health, preschool and early school adjustment programs, programs to improve and augment social and academic supports, programs to intervene prior to referral for intensive treatments, and intensive treatment programs. It should be evident that such a continuum requires meshing together school and community resources and, given the scope of activity, effectiveness and efficiency require formal and long-lasting interprogram collaboration.

> One implication of all this is formulated as the proposition that *a comprehensive, integrated component to address barriers to learning and enhance healthy development is essential* in helping the many who are not benefitting satisfactorily from formal education. Schools and communities are beginning to sense the need to adopt such a perspective. As they do, we will become more effective in our efforts to enable schools to teach, students to learn, families to function constructively, and communities to serve and protect. Such efforts will no longer be treated as supplementary ("add-ons") that are carried out as fragmented and categorical services; indeed, they will be seen as a primary, essential, and integrated component of school reform and restructuring.

Overcoming Barriers to Working Together

> *Treat people as if they were*
> *what they ought to be*
> *and you help them become*
> *what they are capable of being.*
> Goethe

In pursuing their mission, a school's staff must be sensitive to a variety of human, community, and institutional differences and learn strategies for dealing with them. With respect to working with students and their parents, staff members encounter differences in

- sociocultural and economic background and current lifestyle
- primary language spoken
- skin color
- gender
- motivation for help

and much more.

Differences as a Problem

Comparable differences are found in working with school personnel (certificated and non certificated, line staff and administrators). *In addition, there are differences related to power, status, and orientation.* And, for many newcomers to a school, the culture of schools in general and that of a specific school and community may differ greatly from other settings where they have lived and worked.

> For school staff, existing differences may make it difficult to establish effective working relationships with students and others who effect the student. For example, many schools do not have staff who can reach out to students whose primary language is Spanish, Korean, Tagalog, Vietnamese, Cambodian, Armenian, and so forth. And although workshops and presentations are offered in an effort to increase specific cultural awareness, what can be learned in this way is limited, especially when one is in a school of many cultures.

There also is a danger in prejudgments based on apparent cultural awareness. There are many reports of students who have been victimized by professionals who are so sensitized to cultural differences that they treat fourth generation Americans as if they had just migrated from their cultural homeland.

Obviously, it is desirable to hire staff who have the needed language skills and cultural awareness and who do not rush to prejudge. Given the realities of budgets and staff recruitment, however, schools cannot hire a separate specialist for all the major language, cultural, and skin color differences that exist in some schools. Nevertheless, the objectives of accounting for relevant differences while respecting individuality can be appreciated and addressed.

Examples of Client Differences as a Problem

> "A 14 year old Filipino wanted help, but his mother told me her culture doesn't recognize the need for counseling."
>
> "Despite the parents' resistance to accepting the need for treatment, we decided the student had to be sent to the emergency room after the suicide attempt."
>
> "A 15 year old Vietnamese attempted suicide because her parents were forcing her into an arranged marriage."
>
> "An 18 year old Latina student reported suicidal ideation; she expressed extreme resentment toward her father for being so strict that he would not allow her to date."

As these cases illustrate, differences can result in problems for students, parents, and staff. Although such problems are not easily resolved, they are solvable as long as everyone works in the best interests of the student, and the differences are not allowed to become barriers to relating with others.

Differences as a Barrier

As part of a working relationship, differences often are complementary and helpful -- as when staff from different disciplines work with and learn from each other. Differences become a barrier to effective working relationships when negative attitudes are allowed to prevail. Interpersonally, the result generally is conflict and poor communication. For example, differences in status, skin color, power, orientation, and so forth can cause one or more persons to enter the situation with negative (including competitive) feelings. And such feelings often motivate conflict.

BEST COPY AVAILABLE

Many individuals (students, staff) who have been treated unfairly, been discriminated against, been deprived of opportunity and status at school, on the job, and in society use whatever means they can to seek redress and sometimes to strike back. Such an individual may promote conflict in hopes of correcting power imbalances or at least to call attention to a problem. Often, however, power differentials are so institutionalized that individual action has little impact.

"You don't know what it's like to be poor."

"You're the wrong color to understand."

"You're being culturally insensitive."

"How can a woman understand a male student's problems?"

"Male therapists shouldn't work with girls who have been sexually abused."

"I never feel that young professionals can be trusted."

"Social workers (nurses/MDs/ psychologists/teachers) don't have the right training to help these kids."

"How can you expect to work effectively with school personnel when you understand so little about the culture of schools and are so negative toward them and the people who staff them?"

"If you haven't had alcohol or other drug problems, you can't help students with such problems."

"If you don't have teenagers at home, you can't really understand them."

"You don't like sports! How can you expect to relate to teenagers?"

> ***You know, it's a tragedy in a way***
> ***that Americans are brought up to think***
> ***that they cannot feel***
> ***for other people and other beings***
> ***just because they are different.***
> **Alice Walker**

It is hard and frustrating to fight an institution. It is much easier and immediately satisfying to fight with other individuals one sees as representing that institution. However, when this occurs where individuals are supposed to work together, those with negative feelings may act and say things in ways that produce significant barriers to establishing a working relationship. Often, the underlying message is "you don't understand," or worse yet "you probably don't want to understand." Or, even worse, "you are my enemy."

> It is unfortunate when such barriers arise between students and those trying to help them; it is a travesty when such barriers interfere with the helpers working together effectively. Staff conflicts detract from accomplishing goals and contribute in a major way to "burn out."

Overcoming Barriers Related to Differences

When the problem is **only** one of poor skills, it is relatively easy to overcome. Most motivated professionals can be directly taught ways to improve communication and avoid or resolve conflicts that interfere with working relationships. There are, however, no easy solutions to overcoming deeply embedded negative attitudes. Certainly, a first step is to understand that the nature of the problem is not differences per se but negative perceptions stemming from the politics and psychology of the situation.

It is these perceptions that lead to

- prejudgments that a person is bad because of an observed difference

and

- the view that there is little to be gained from working with that person.

Thus, minimally, the task of overcoming negative attitudes interfering with a particular working relationship is twofold. To find ways

- to counter negative prejudgments (e.g., to establish the credibility of those who have been prejudged)

and

- to demonstrate there is something of value to be gained from working together.

Building Rapport and Connection

To be effective in working with another person (student, parent, staff), you need to build a positive relationship around the **tasks** at hand.

Necessary ingredients in building a working relationship are

- minimizing negative prejudgments about those with whom you will be working (see Exhibit 9)
- taking time to make connections
- identifying what will be gained from the collaboration in terms of mutually desired outcomes -- to clarify the value of working together
- enhancing expectations that the working relationship will be productive -- important here is establishing credibility with each other
- establishing a structure that provides support and guidance to aid task focus
- periodic reminders of the positive outcomes that have resulted from working together

With specific respect to **building relationships** and **effective communication**, three things you can do are:

- convey empathy and warmth (e.g., the ability to understand and appreciate what the individual is thinking and feeling and to transmit sense of liking)
- convey genuine regard and respect (e.g., the ability to transmit real interest and to interact in a way that enables the individual to maintain a feeling of integrity and personal control)
- talk with, not at, others -- active listening and dialogue (e.g., being a good listener, not being judgmental, not prying, sharing your experiences as appropriate and needed)

Finally, watch out for ego-oriented behavior (yours and theirs) -- it tends to get in the way of accomplishing the task at hand.

Exhibit 9: Accounting for Cultural, Racial, and Other Significant Individual and Group Differences

All interventions to address barriers to learning and promote healthy development must consider significant individual and group differences.

In this respect, discussions of diversity and cultural competence offer some useful concerns to consider and explore. For example, the Family and Youth Services Bureau of the U.S. Department of Health and Human Services, in a 1994 document entitled *A Guide to Enhancing the Cultural Competence of Runaway and Homeless Youth Programs,* outlines some baseline assumptions which can be broadened to read as follows:

> Those who work with youngsters and their families can better meet the needs of their target population by enhancing their competence with respect to the group and its intragroup differences.
>
> Developing such competence is a dynamic, on-going process -- not a goal or outcome. That is, there is no single activity or event that will enhance such competence. In fact, use of a single activity reinforces a false sense of that the "problem is solved."
>
> Diversity training is widely viewed as important, but is not effective in isolation. Programs should avoid the "quick fix" theory of providing training without follow-up or more concrete management and programmatic changes.
>
> Hiring staff from the same background as the target population does not necessarily ensure the provision of appropriate services, especially if those staff are not in decision-making positions, *or* are not themselves appreciative of, or respectful to, group and intragroup differences.
>
> Establishing a process for enhancing a program's competence with respect to group and intragroup differences is an opportunity for positive organizational and individual growth.

(cont.)

Exhibit 9: (cont.) **Accounting for Cultural, Racial, and Other Significant Individual and Group Differences**

The Bureau document goes on to state that programs:

> are moving from the individually-focused "medical model" to a clearer understanding of the many external causes of our social problems ... why young people growing up in intergenerational poverty amidst decaying buildings and failing inner-city infrastructures are likely to respond in rage or despair. It is no longer surprising that lesbian and gay youth growing up in communities that do not acknowledge their existence might surrender to suicide in greater numbers than their peers. We are beginning to accept that social problems are indeed more often the problems of society than the individual.
>
> These changes, however, have not occurred without some resistance and backlash, nor are they universal. Racism, bigotry, sexism, religious discrimination, homophobia, and lack of sensitivity to the needs of special populations continue to affect the lives of each new generation. Powerful leaders and organizations throughout the country continue to promote the exclusion of people who are "different," resulting in the disabling by-products of hatred, fear, and unrealized potential.
>
> ... We will not move toward diversity until we promote inclusion ... Programs will not accomplish any of (their) central missions unless ... (their approach reflects) knowledge, sensitivity, and a willingness to learn.

In their discussion of "The Cultural Competence Model," Mason, Benjamin, and Lewis* outline five cultural competence values which they stress are more concerned with behavior than awareness and sensitivity and should be reflected in staff attitude and practice and the organization's policy and structure. In essence, these five values are

(1) *Valuing Diversity* -- which they suggest is a matter of framing cultural diversity as a strength in clients, line staff, administrative personnel, board membership, and volunteers.

(2) Conducting Cultural Self-Assessment -- to be aware of cultural blind spots and ways in which one's values and assumptions may differ from those held by clients.

(3) *Understanding the Dynamics of Difference* -- which they see as the ability to understand what happens when people of different cultural backgrounds interact.

(4) *Incorporating Cultural Knowledge* -- seen as an ongoing process.

(5) *Adapting to Diversity* -- described as modifying direct interventions and the way the organization is run to reflect the contextual realities of a given catchment area and the sociopolitical forces that may have shaped those who live in the area.

*In *Families and the Mental Health System for Children and Adolescence*, edited by C.A. Heflinger & C.T. Nixon (1996). CA: Sage Publications.

One Other Observation

In most situations, direct or indirect accusations that *"You don't understand"* are valid. Indeed, they are givens. After all, it is usually the case that one does not fully understand complex situations or what others have experienced and are feeling.

> With respect to efforts to build working relationships, accusing someone of not understanding tends to create major barriers. This is not surprising since the intent of such accusations generally is to make others uncomfortable and put them on the defensive.

It is hard to build positive connections with a defensive person. Avoidance of *"You don't understand"* accusations may be a productive way to reduce at least one set of major barriers to establishing working relationships.

> Finally, it is essential to remember that **individual differences** are the most fundamental determinant of whether a good relationship is established. This point was poignantly illustrated by the recent experience of the staff at one school.

> A Korean student who had been in the U.S.A. for several years and spoke comprehensible English came to the center seeking mental health help for a personal problem. The center's policy was to assign Korean students to Asian counselors whenever feasible. The student was so assigned, met with the counselor, but did not bring up his personal problem. This also happened at the second session, and then the student stopped coming.
>
> In a follow-up interview conducted by a nonAsian staff member, the student explained that the idea of telling his personal problems to another Asian was too embarrassing.
>
> Then, why had he come in the first place?
>
> Well, when he signed up, he did not understand he would be assigned to an Asian; indeed, he had expected to work with the "blue-eyed counselor" a friend had told him about.

BEST COPY AVAILABLE

Coda: Enhancing Available Resources

Besides striving to build a sound financial base, SBHCs can enhance their ability to contribute to the mental health of increasing numbers of students by coordinating and integrating with other school and community programs.

Coordination and integration begins with establishing and maintaining ways to

- build effective working relationships among center, school, and community programs
- monitor and problem solve with respect to individual student needs.

Once the matter of coordination and integration is addressed, it is time to direct efforts toward expanding intervention options with respect to

- service options for students with psychosocial problems
- prevention and positive mental health programs
- activities to improve the school's psychosocial climate
- attending to other environmental concerns that address social bases of students' problems.

Any effort to enhance resources requires organizing for advocacy. Advocacy and related action to improve resource availability has many facets. It may be formal or informal, explicitly outlined or covert, highly organized or relatively uncoordinated. It may take the form of case-by-case or class advocacy and action; it may extend to concern about the proper focus for training and research activity. Besides its form and focus, advocacy also involves a variety of strategies ranging from dissemination of information to legislative lobbying and litigation.

> Given the challenges facing school-based centers, there is a need for ongoing policy analyses and development of an agenda for advocacy and related programmatic action. Such an agenda can only arise out of the combined efforts of those who assume leadership roles in this dynamic new movement. And such combined effort requires organization (e.g, regional and national leadership training workshops, leadership advisory councils).

The need for organization has given rise to the *National Assembly on School-Based Health Care* and its state affiliates.* As indicated at the end of the guidebook's introductory chapter the mission of several other organizations also has resulted in a variety of supports for SBHCs (e.g., *Advocacy for Youth, Making the Grade*, the *Center for Mental Health Assistance at the University of Maryland at Baltimore*, the *UCLA Center for Mental Health in Schools*).

Overcoming today's limitations and meeting tomorrow's challenges requires a clear picture of where we want to go and how we can get there. Over the next few years, we all have the opportunity to play an important role in creating that picture.

---

*This group was formed in 1995 to promote and assure quality primary health care for children and youth. The organization views school-based health centers as representing an essential element in meeting this aim. You can contact the National Assembly on School-Based Health Care at: 6728 Old McLean Village Drive, McLean, VA 22101.

RESOURCE AIDS

A. Resource Aids Included Here

Resource Aid IB-1:

Survey Instruments to Aid in Mapping and Analyzing Existing School-Based/ Linked Psychosocial and Mental Health Systems, Programs, and Services

In addition to an overview **survey of system status,** separate instruments are included for surveying the status and interest in programs related to

- prescribed **student and family assistance**
- **crisis assistance and prevention**
- **support for transitions**
- **home involvement in schooling**
- **classroom-based efforts** to enhance learning and performance of those with mild-moderate learning, behavior, and emotional problems
- outreaching to develop greater **community involvement** and support -- including recruitment of volunteers

Resource Aid IB-2:

Developing a Resource Coordinating Team

This handout describes the nature and functions of a Resource Coordinating Team and steps in developing such a mechanism.

Resource Aid IB-3:

Developing a Complex (Multisite) Resource Coordinating Council

This handout describes the nature and functions of a Complex Resource Coordinating Council and developmental steps.

B. Related Resource Aid Packet Avaialable from Our Center

Working Together: From School-Based Collaborative Teams to School-Community-Higher Education Connections

Discusses processes and problems related to working together at school sites and in school-based centers. Outlines models of collaborative school-based teams and interprofessional education.

(Survey instruments to aid in mapping and analyzing school-based/linked psychosocial and mental health resources*)

Survey of System Status

As your school sets out to enhance the usefulness of education support programs designed to address barriers to learning, it helps to clarify what you have in place as a basis for determining what needs to be done. You will want to pay special attention to

- *clarifying what resources already are available*
- *how the resources are organized to work in a coordinated way*
- *what procedures are in place for enhancing resource usefulness*

This survey provides a starting point.

Items 1-6 ask about what processes are in place.
Use the following ratings in responding to these items.

DK = don't know
1 = not yet
2 = planned
3 = just recently initiated
4 = has been functional for a while
5 = well institutionalized (well established with a commitment to maintenance)

Items 7- 10 ask about effectiveness of existing processes.
Use the following ratings in responding to these items.

DK = don't know
1 = hardly ever effective
2 = effective about 25 % of the time
3 = effective about half the time
4 = effective about 75% of the time
5 = almost always effective

*These surveys were designed as part of our Center's work related to the concept of an enabling component. You can read about this concept by turning to the last section of the Guidebook entitled -- *Coda: Toward a Comprehensive, Integrated Approach to Addressing Barriers to Student Learning.*

DK = don't know
1 = not yet
2 = planned
3 = just recently initiated
4 = has been functional for a while
5 = well institutionalized

1. Is someone at the school designated as coordinator/leader for activity designed to address barriers to learning (e.g., education support programs, health and social services, the Enabling Component)? DK 1 2 3 4 5

2. Is there a time and place when personnel involved in activity designed to address barriers to learning meet together? DK 1 2 3 4 5

3. Do you have a Resource Coordinating Team? DK 1 2 3 4 5

4. Do you have written descriptions available to give staff (and parents when applicable) regarding

   (a) activities available at the site designed to address barriers to learning (programs, teams, resources, services -- including parent and family service centers if you have them)? DK 1 2 3 4 5

   (b) resources available in the community? DK 1 2 3 4 5

   (c) a system for staff to use in making referrals? DK 1 2 3 4 5

   (d) a system for triage (to decide how to respond when a referral is made)? DK 1 2 3 4 5

   (e) a case management system? DK 1 2 3 4 5

   (f) a student study team? DK 1 2 3 4 5

   (g) a crisis team? DK 1 2 3 4 5

   (h) Specify below any other relevant programs/services -- including preventive approaches (e.g., prereferral interventions; welcoming, social support, and articulation programs to address transitions; programs to enhance home involvement in schooling; community outreach and use of volunteer)?

   ______________________________ DK 1 2 3 4 5

   ______________________________ DK 1 2 3 4 5

   ______________________________ DK 1 2 3 4 5

   ______________________________ DK 1 2 3 4 5

5. Are there effective processes by which staff and families learn

   (a) what is available in the way of programs/services? DK 1 2 3 4 5

   (b) how to access programs/services they need? DK 1 2 3 4 5

6. With respect to your complex/cluster's activity designed to address barriers to learning has someone at the school been designated as a representative to meet with the other schools? DK 1 2 3 4 5

DK = don't know
1 = not yet
2 = planned
3 = just recently initiated
4 = has been functional for a while
5 = well institutionalized

7. How effective is the

(a) referral system? DK 1 2 3 4 5

(b) triage system? DK 1 2 3 4 5

(c) case management system? DK 1 2 3 4 5

(d) student study team? DK 1 2 3 4 5

(e) crisis team? DK 1 2 3 4 5

8. How effective are the processes for

(a) planning, implementing, and evaluating system improvements (e.g., related to referral, triage, case management, student study team, crisis team, prevention programs)? DK 1 2 3 4 5

(b) enhancing resources for assisting students and family (e.g., through staff development; developing or bringing new programs/services to the site; making formal linkages with programs/services in the community)? DK 1 2 3 4 5

9. How effective are the processes for ensuring that

(a) resources are properly allocated and coordinated? DK 1 2 3 4 5

(b) linked community services are effectively coordinated/integrated with related activities at the site? DK 1 2 3 4 5

10. How effective are the processes for ensuring that resources available to the whole complex/cluster are properly allocated and shared/coordinated? DK 1 2 3 4 5

Please list community resources with which you have formal relationships.

(a) Those that bring program(s) to the school site

(b) Those not at the school site but which have made a special commitment to respond to the school's referrals and needs.

Classroom-Focused Enabling

The emphasis here is on enhancing classroom-based efforts to enable learning by increasing teacher effectiveness for preventing and handling problems in the classroom. This is accomplished by providing personalized help to increase a teacher's array of strategies for working with a wider range of individual differences (e.g., through use of accommodative and compensatory strategies, peer tutoring and volunteers to enhance social and academic support, resource and itinerant teachers and counselors in the classroom). Through classroom-focused enabling programs, teachers are better prepared to address similar problems when they arise in the future. Anticipated outcomes are increased mainstream efficacy and reduced need for special services.

Please indicate all items that apply.

A. What programs for personalized professional development are currently at the site?	**Yes**	**Yes but more of this is needed**	**No**	**If no, is this something you want**
1. Are teachers clustered for support and staff development?	___	___	___	___
2. Are models used to provide demonstrations?	___	___	___	___
3. Are workshops and readings offered regularly?	___	___	___	___
4. Is consultation available from persons with special expertise such as				
a. members of the Student Study Team?	___	___	___	___
b. resource specialists and/or special education teachers?	___	___	___	___
c. members of special committees?	___	___	___	___
d. bilingual and/or other coordinators?	___	___	___	___
e. counselors?	___	___	___	___
f. other? (specify) ____________________	___	___	___	___
5. Is there a formal mentoring program?	___	___	___	___
6. Is there staff social support?	___	___	___	___
7. Is there formal conflict mediation/resolution for staff?	___	___	___	___
8. Assistance in learning to use advanced technology?	___	___	___	___
9. other (specify) ____________________	___	___	___	___
B. What additional things are done in the classroom to help students identified as having problems?				
1. Are "personnel" added to the class (or before/after school)? If yes, what types of personnel are brought in:				
a. aides?	___	___	___	___
b. older students?	___	___	___	___
c. other students in the class?	___	___	___	___
d. volunteers?	___	___	___	___
e. parents?	___	___	___	___
f. resource teacher?	___	___	___	___
g. specialists?	___	___	___	___
h. other? (specify)____________________	___	___	___	___

Classroom-Focused Enabling (cont.)

2. Are materials and activities upgraded to	Yes	Yes but more of this is needed	No	If no, is this something you want?
a. ensure there are enough basic supplies in the classroom?	___	___	___	___
b. increase the range of high-motivation activities (keyed to the interests of students in need of special attention)?	___	___	___	___
c. include advanced technology as a new option?	___	___	___	___
d. other? (specify) ____________________	___	___	___	___
C. What is done to assist a teacher who has difficulty with limited English speaking students?				
1. Is the student reassigned?	___	___	___	___
2. Does the teacher receive professional development related to working with limited English speaking students?	___	___	___	___
3. Does the bilingual coordinator offer consultation?	___	___	___	___
4. Is a bilingual aide assigned to the class?	___	___	___	___
5. Are volunteers brought in to help (e.g., parents, peers)?	___	___	___	___
6. other? (specify) ____________________	___	___	___	___
D. What types of technology are available to the teachers?				
1. Are there computers in the classroom?	___	___	___	___
2. Is there a computer lab?	___	___	___	___
3. Is computer assisted instruction offered?	___	___	___	___
4. Are there computer literacy programs?	___	___	___	___
5. Is the Writing to Read program (Spanish/English) used?	___	___	___	___
6. Does the classroom have video recording capability?	___	___	___	___
7. Is instructional TV used in the classroom?				
a. videotapes?	___	___	___	___
b. PBS?	___	___	___	___
8. Is there a multimedia lab?	___	___	___	___
9. other? (specify) ____________________	___	___	___	___
E. What curricular enrichment and adjunct programs do teachers use?				
1. Are library activities used regularly?	___	___	___	___
2. Is music/art used regularly?	___	___	___	___
3. Is health education a regular part of the curriculum?	___	___	___	___

Classroom-Focused Enabling (cont.)

	Yes	Yes but more of this is needed	No	If no is this something you wa
4. Are student performances regular events?	___	___	___	___
5. Are there several field trips a year?	___	___	___	___
6. Are there student council and other leadership opportunities?	___	___	___	___
7. Are there school environment projects such as				
a. mural painting?	___	___	___	___
b. horticulture/gardening?	___	___	___	___
c. school clean-up and beautification?	___	___	___	___
d. other? (specify) ______________________________	___	___	___	___
8. Are there special school-vide events such as				
a. clubs and similar organized activities?	___	___	___	___
b. publication of a student newspaper?	___	___	___	___
c. sales events (candy, t shirts)?	___	___	___	___
d. poster contests?	___	___	___	___
e. essay contests?	___	___	___	___
f. a book fair?	___	___	___	___
g. pep rallies/contests?	___	___	___	___
h. attendance competitions?	___	___	___	___
i. attendance awards/assemblies?	___	___	___	___
j. other? (specify) ______________________________	___	___	___	___
9. Are "guest' contributors used (e.g., outside speakers/performers)?	___	___	___	___
10. Other? (specify) ______________________________	___	___	___	___
F. What programs for temporary out of class help are currently at the site?				
1. Is there a family center providing student and family assistance?	___	___	___	___
2. Are there designated problem remediation specialists?	___	___	___	___
3. Is there a "time out" room?	___	___	___	___
4. other? (specify) ______________________________	___	___	___	___

G. What programs are used to train aides, volunteers, and other "assistants" who come into the classrooms to work with students who need help?

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Classroom-Focused Enabling (cont.)

	Yes	Yes but more of this is needed	No	If no is this somethin you want
H. Which of the following can teachers request as special interventions?				
1. family problem solving conferences	___	___	___	___
2. exchange of students as an opportunity for improving the match and for a fresh start	___	___	___	___
3. referral for specific services	___	___	___	___
4. other (specify) ______________________	___	___	___	___
I. Is there ongoing training for team members concerned with the area of Classroom-Focused Enabling?	___	___	___	___

J. Please indicate below any other ways that are used at the school to assist a teacher's efforts to address barriers to students' learning.

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

K. Please indicate below other things you want the school to do to assist a teacher's efforts to address barriers to students' learning.

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Support for Transitions

The emphasis here is on planning, developing, and maintaining a comprehensive focus on the variety of transition concerns confronting students and their families. The work in this area can be greatly aided by advanced technology. Anticipated outcomes are reduced levels of alienation and increased levels of positive attitudes toward and involvement at school and in a range of learning activity.

Please indicate all items that apply.

A. What programs for establishing a welcoming and supportive community are at the site?	Yes	Yes but more of this is needed	No	If no, is this something you want?
1. Are there welcoming materials/a welcoming decor?	___	___	___	___
Are there welcome signs?	___	___	___	___
Are welcoming information materials used?	___	___	___	___
Is a special welcoming booklet used?	___	___	___	___
Are materials translated into appropriate languages?	___	___	___	___
Is advanced technology used as an aid?	___	___	___	___
2. Are there orientation programs?	___	___	___	___
Are there introductory tours?	___	___	___	___
Are introductory presentations made?	___	___	___	___
Are new arrivals introduced to special people such as the principal and teachers?	___	___	___	___
Are special events used to welcome recent arrivals?	___	___	___	___
Are different languages accommodated?	___	___	___	___
3. Is special assistance available to those who need help registering?	___	___	___	___
4. Are social support strategies and mechanisms used?	___	___	___	___
Are peer buddies assigned?	___	___	___	___
Are peer parents assigned?	___	___	___	___
Are special invitations used to encourage family involvement?	___	___	___	___
Are special invitations used to encourage students to join in activities?	___	___	___	___
Are advocates available when new arrivals need them?	___	___	___	___
5. Other? (specify) ______________________	___	___	___	___
B. Which of the following transition programs are in use for grade-to-grade and program-to-program articulation?				
1. Are orientations to the new situation provided?	___	___	___	___
2. Is transition counseling provided?	___	___	___	___
3. Are students taken on "warm-up" visits?	___	___	___	___
4. Is there a "survival" skill training program?	___	___	___	___
5. Is the new setting primed to accommodate the individual's needs?	___	___	___	___
6. other (specify) ______________________	___	___	___	___

Support for Transitions (cont.)

	Yes	Yes but more of this is needed	No	If no, is this something you want?
C. Which of the following are used to facilitate transition to post school living?				
1. vocational counseling	___	___	___	___
2. college counseling	___	___	___	___
3. a mentoring program	___	___	___	___
4. job training	___	___	___	___
5. job opportunities on campus	___	___	___	___
6. a work-study program	___	___	___	___
7. life skills counseling	___	___	___	___
8. Other? (specify) ______________________________	___	___	___	___
D. Which of the following before and after school programs are available?				
1. subsidized breakfast/lunch program	___	___	___	___
2. recreation program	___	___	___	___
3. sports program	___	___	___	___
4. Youth Services Program	___	___	___	___
5. youth groups such as drill team				
interest groups	___	___	___	___
service clubs	___	___	___	___
organized youth programs ("Y,' scouts)	___	___	___	___
CA. Cadet Corps	___	___	___	___
other (specify)___________________________	___	___	___	___
6. academic support in the form of				
tutors	___	___	___	___
homework club	___	___	___	___
study ball	___	___	___	___
homework phone line	___	___	___	___
homework center	___	___	___	___
other (specify) _____________________________	___	___	___	___
7. enrichment opportunities (including classes)	___	___	___	___
8. Other (specify) ______________________________	___	___	___	___

Support for Transitions (cont.)

	Yes	Yes but more of this is needed	No	If no, is this somethin you want
E. Which of the following programs are offered during intersession?				
1. recreation	___	___	___	___
2. sports	___	___	___	___
3. Youth Services	___	___	___	___
4. youth groups	___	___	___	___
5. academic support	___	___	___	___
6. enrichment opportunities (including classes)	___	___	___	___
7. other (specify) ______________________	___	___	___	___
F. What programs are used to meet the educational needs of personnel related to this programmatic area?				
1. Is there ongoing training for team members concerned with the area of Support for Transitions?	___	___	___	___
2. Is there ongoing training for staff of specific services/ programs? (e.g., teachers, peer buddies, office staff, administrators)?	___	___	___	___
3. Other? (specify) ______________________	___	___	___	___
G. Which of the following topics are covered in educating stakeholders?				
1. understanding how to create a psychological sense of community	___	___	___	___
2. developing systematic social supports for students, families, and staff	___	___	___	___
3. developing motivation knowledge, and skills for successful transitions	___	___	___	___
4. the value of and strategies for creating before and after school programs	___	___	___	___

Support for Transitions (cont.)

H. Please indicate below any other ways that are used to provide support for transitions.

I. Please indicate below other things you want the school to do to provide support for transitions.

Student and Family Assistance Programs and Services

The emphasis here is on providing special services in a personalized way to assist with a broad-range of needs. To begin with, available social, physical and mental health programs in the school and community are used. As community outreach brings in other resources, they are linked to existing activity in an integrated manner. Special attention is paid to enhancing systems for triage, case and resource management, direct services to meet immediate needs, and referral for special services and specialeducation resources and placements as appropriate. Intended outcomes are to ensure special assistance is provided when necessary and appropriate and that such assistance is effective.

Please indicate all items that apply.

	Yes	**Yes but more of this is needed**	**No**	**If no, is this something you want?**
A. Are there classroom focused enabling programs to reduce the need for teachers to seek special programs and services?	___	___	___	___
B. What activity is there to facilitate and evaluate requests for assistance?				
1. Does the site have a directory that lists services and programs?	___	___	___	___
2. Is information circulated about services/programs?	___	___	___	___
3. Is information circulated clarifying how to make a referral?	___	___	___	___
4. Is information about services, programs, and referral procedures updated periodically?	___	___	___	___
5. Is a triage process used to assess				
a. specific needs?	___	___	___	___
b. priority for service?	___	___	___	___
6. Are procedures in place to ensure use of prereferral interventions?	___	___	___	___
7. Do inservice programs focus on teaching the staff ways to prevent unnecessary referrals?	___	___	___	___
8. Other? (specify) ______________________	___	___	___	___
C. After triage, how are referrals handled?				
1. Is detailed information provided about available services (e.g., is an annotated community resource system available)?	___	___	___	___
2. Is there a special focus on facilitating effective decision making?	___	___	___	___
3. Are students/families helped to take the necessary steps to connect with a service or program to which they have been referred?	___	___	___	___
4. Other? (specify) ______________________	___	___	___	___

Student and Family Assistance Programs and Services (cont.)

D. What types of direct interventions are provided currently?	**Yes**	**Yes but more of this is needed**	**No**	**If no, is this something you want?**
1. Which medical services and programs are provided?				
a. immunizations	___	___	___	___
b. first aid and emergency care	___	___	___	___
c. crisis follow-up medical care	___	___	___	___
d. health and safety education and counseling	___	___	___	___
e. screening for vision problems	___	___	___	___
f. screening for hearing problems	___	___	___	___
g. screening for health problems (specify)	___	___	___	___
h. screening for dental problems (specify)	___	___	___	___
i. treatment of some acute problems (specify)	___	___	___	___
j. other (specify) ______________________________	___	___	___	___
2. Which psychological services and programs are provided?				
a. psychological first aid	___	___	___	___
b. crisis follow-up counseling	___	___	___	___
c. crisis hotlines	___	___	___	___
d. conflict mediation	___	___	___	___
e. alcohol and other drug abuse programs	___	___	___	___
f. pregnancy prevention program	___	___	___	___
g. gang prevention program	___	___	___	___
h. dropout prevention program	___	___	___	___
I. physical and sexual abuse prevention	___	___	___	___
j. individual counseling	___	___	___	___
k. group counseling	___	___	___	___
1. family counseling	___	___	___	___
m. mental health education	___	___	___	___
n. home outreach	___	___	___	___
o. other (specify) ______________________________	___	___	___	___
3. Which of the following are provided to meet basic survival needs?				
a. emergency food	___	___	___	___
b. emergency clothing	___	___	___	___
c. emergency housing	___	___	___	___
d. transportation support	___	___	___	___
e. welfare services	___	___	___	___
f. language translation	___	___	___	___
g. legal aid	___	___	___	___
h. protection from physical abuse	___	___	___	___
I. protection from sexual abuse	___	___	___	___
j. employment assistance	___	___	___	___
k. other (specify) ______________________________	___	___	___	___

Student and Family Assistance Programs and Services (cont.)

4. Which of the following special education, Special Eligibility, and independent study programs and services are provided?	Yes	Yes but more of this is needed	No	If no, is this somethin you wan
a. early education program	___	___	___	___
b. special day classes (specify) ________________	___	___	___	___
c. speech and language therapy	___	___	___	___
d. adaptive P. E.	___	___	___	___
e. special assessment	___	___	___	___
f. Resource Specialist Program	___	___	___	___
g. Chapter I	___	___	___	___
h. School Readiness Language Develop. Program (SRLDP)	___	___	___	___
i. other (specify) ________________	___	___	___	___
5. Which of the following adult education programs are provided?				
a. ESL	___	___	___	___
b. citizenship classes	___	___	___	___
c. basic literacy skills	___	___	___	___
d. parenting	___	___	___	___
e. helping children do better at school	___	___	___	___
f. other (specify) ________________	___	___	___	___
6. Are services and programs provided to enhance school readiness? specify ________________	___	___	___	___
7. Which of the following are provided to address attendance problems?				
a. absence follow-up	___	___	___	___
b. attendance monitoring	___	___	___	___
c. first day calls	___	___	___	___
8. Are discipline proceedings carried out regularly?	___	___	___	___
9. Other? (specify) ________________	___	___	___	___
E. Which of the following are used to manage cases and resources?				
1. Is a student information system used?	___	___	___	___
2. Is a system used to trail progress of students and their families?	___	___	___	___
3. Is a system used to facilitate communication for	___	___	___	___
a. case management?	___	___	___	___
b. resource and system management?	___	___	___	___

Student and Family Assistance Programs and Services (cont.)

	Yes	Yes but more of this is needed	No	If no, is this somethi you wa
4. Are there follow-up systems to determine				
a. referral follow-through?	___	___	___	___
b. consumer satisfaction with referrals?	___	___	___	___
c. the need for more help?	___	___	___	___
5. Other? (specify) ______________________	___	___	___	___
F. Which of the following are used to help enhance the quality and quantity of services and programs?				
1. Is a quality improvement system used?	___	___	___	___
2. Is a mechanism used to coordinate and integrate services/programs?	___	___	___	___
3. Is there outreach to link-up with community services and programs?	___	___	___	___
4. Is a mechanism used to redesign current activity as new collaborations are developed?	___	___	___	___
5. Other? (specify) ______________________	___	___	___	___
G. What programs are used to meet the educational needs of personnel related to this programmatic area?				
1. Is there ongoing training for team members concerned with the area of Student and Family Assistance?	___	___	___	___
2. Is there ongoing training for staff of specific services/programs (e.g., Assessment and Consultation Team, direct service providers)?	___	___	___	___
3. Other? (specify) ______________________	___	___	___	___
H. Which of the following topics are covered in educating stakeholders?				
1. broadening understanding of causes of learning, behavior, and emotional problems	___	___	___	___
2. broadening understanding of ways to ameliorate (prevent, correct) learning, behavior, and emotional problems	___	___	___	___
3. developing systematic academic supports for students in need	___	___	___	___
4. what classroom teachers and the home can do to minimize the need for special interventions	___	___	___	___

Home Involvement in Schooling (cont.)

	Yes	Yes but more of this is needed	No	If no, is this somethin you want
2. Are education programs offered on				
a. childrearing/parenting?	___	___	___	___
b. creating a supportive home environment for students?	___	___	___	___
c. reducing factors that interfere with a student's school learning and performance?	___	___	___	___
3. Are guidelines provided for helping a student deal with homework?	___	___	___	___
4. Other? (specify) ______________________	___	___	___	___

C. Which of the following are in use to improve communication about matters essential to the student and family?

1. Are there periodic general announcements and meetings such as				
a. advertising for incoming students?	___	___	___	___
b. orientation for incoming students and families?	___	___	___	___
c. bulletins/newsletters?	___	___	___	___
d. back to school night/open house?	___	___	___	___
e. parent teacher conferences?	___	___	___	___
g. other? (specify) ______________________	___	___	___	___
2. Is there a system to inform the home on a regular basis				
a. about general school matters?	___	___	___	___
b. about opportunities for home involvement?	___	___	___	___
c. other? (specify) ______________________	___	___	___	___
3. To enhance home involvement in the student's program and progress, are interactive communications used, such as				
a. sending notes home regularly?	___	___	___	___
b. a computerized phone line?	___	___	___	___
c. frequent in-person conferences with the family?	___	___	___	___
d. other? (specify) ______________________	___	___	___	___
4. Other? (specify) ______________________	___	___	___	___

D. Which of the following are used to enhance the home-school connection and sense of community?

1. Does the school offer orientations and open houses?	___	___	___	___
2. Does the school have special receptions for new families?	___	___	___	___

Home Involvement in Schooling (cont.)

	Yes	**Yes but more of this is needed**	**No**	**If no, is this somethi you wan**
3. Does the school regularly showcase students to the community through				
a. student performances?	___	___	___	___
b. award ceremonies?	___	___	___	___
c. other? (specify) ______________________________	___	___	___	___
4. Does the school offer the community				
a. cultural and sports events?	___	___	___	___
b. topical workshops and discussion groups?	___	___	___	___
c. health fairs	___	___	___	___
d. family preservation fairs	___	___	___	___
e. work fairs	___	___	___	___
f. newsletters	___	___	___	___
g. community bulletin boards	___	___	___	___
h. community festivals and celebrations	___	___	___	___
i. other (specify) ________________________________	___	___	___	___
5. Is there outreach to hard to involve families such as				
a. making home visits?	___	___	___	___
b. offering support networks?	___	___	___	___
c. other? (specify) ______________________________	___	___	___	___
6. Other? (specify) ________________________________	___	___	___	___
E. Which of the following are used to enhance family participation in decision making essential to the student?				
1. Families are invited to participate through personal				
a. letters	___	___	___	___
b. phone calls	___	___	___	___
c. other (specify) ______________________________	___	___	___	___
2. Families are informed about schooling choices through				
a. letters	___	___	___	___
b. phone calls	___	___	___	___
c. conferences	___	___	___	___
d. other (specify) ______________________________	___	___	___	___
3. Families are taught skills to participate effectively in decision making.	___	___	___	___
4. Staff are specially trained to facilitate family participation in decision making meetings.	___	___	___	___
5. Other (specify) ________________________________	___	___	___	___

Student and Family Assistance Programs and Services (cont.)

	Yes	Yes but more of this is needed	No	If no, is this something you want?
5. enhancing resource quality, availability, and scope	___	___	___	___
6. enhancing the referral system and ensuring effective follow-through	___	___	___	___
7. enhancing the case management system in ways that increase service efficacy	___	___	___	___
8. other (specify) ______________________	___	___	___	___

I. Please indicate below any other ways that are used to provide student and family assistance to address barriers to students' learning.

J. Please indicate below other things you want the school to do to provide student and family assistance to address barriers to students' learning.

Crisis Assistance and Prevention

The emphasis here is on responding to,, minimizing the impact of, and preventing crises. If there is a school-based Family/Community Center facility, it provides a staging area and context for some of the programmatic activity. Intended outcomes of crisis assistance include ensuring immediate assistance is provided when emergencies arise and follow-up care is provided when necessary and appropriate so that students are able to resume learning without undue delays. Prevention activity outcomes are reflected in the creation of a safe and productive environment and the development of student and family attitudes about and capacities for dealing with violence and other threats to safety.

Please indicate all items that apply.

A. With respect to Emergency/Crisis Response:	**Yes**	**Yes but more of this is needed**	**No**	**If no, is this somethin you want?**
1. Is there an active Crisis Team?	___	___	___	___
2. Is the Crisis Team appropriately trained?	___	___	___	___
3. Is there a plan that details a coordinated response				
a. for all at the school site?	___	___	___	___
b. with other schools in the complex?	___	___	___	___
c. with community agencies?	___	___	___	___
4. Are emergency/crisis plans updated appropriately with regard to				
a. crisis management guidelines (e.g., flow charts, check list)?	___	___	___	___
b. plans for communicating with homes/community?	___	___	___	___
c. media relations guidelines?	___	___	___	___
5. Are stakeholders regularly provided with information about emergency response plans?	___	___	___	___
6. Is medical first aid provided when crises occur?	___	___	___	___
7. Is psychological first aid provided when crises occur?	___	___	___	___
8. Is follow-up assistance provided after the crises?				
a. for short-term follow-up assistance?	___	___	___	___
b. for longer-term follow-up assistance?	___	___	___	___
9. Other? (specify) ________________________	___	___	___	___

Crisis Assistance and Prevention (cont.)

	Yes	**Yes but more of this is needed**	**No**	**If no, is this something you want?**
B. With respect to developing programs to prevent crises, are there programs for				
1. school and community safety/violence reduction?	___	___	___	___
2. suicide prevention?	___	___	___	___
3. child abuse prevention?	___	___	___	___
4. sexual abuse prevention?	___	___	___	___
5. substance abuse prevention?	___	___	___	___
6. other (specify) ______________________	___	___	___	___
C. What programs are used to meet the educational needs of personnel related to this programmatic area?				
1. Is there ongoing training for team members concerned with the area of Crisis Assistance and Prevention?	___	___	___	___
2. Is there ongoing training for staff of specific services/programs?	___	___	___	___
3. Other? (specify) ______________________	___	___	___	___
D. Which of the following topics are covered in educating stakeholders?				
1. how to respond when an emergency arises	___	___	___	___
2. how to access assistance after an emergency (including watching for post traumatic psychological reactions)	___	___	___	___
3. indicators of abuse and potential suicide and what to do	___	___	___	___
4. how to respond to concerns related to death, dying, and grief	___	___	___	___
5. how to mediate conflicts and minimize violent reactions	___	___	___	___
6. other (specify) ______________________	___	___	___	___

E. Please indicate below any other ways that are used to provide crisis assistance and prevention to address barriers to students' learning.

________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

F. Please indicate below other things you want the school to do to provide crisis assistance and prevention to address barriers to students' learning.

________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

Home Involvement in Schooling

The emphasis here is on enhancing home involvement through programs to address specific parent learning and support needs (e.g., ESL classes, mutual support groups), mobilize parents as problem solvers when their child has problems (e.g., parent education, instruction in helping with schoolwork), elicit help from families in addressing the needs of the community, and so forth. The context for some of this activity may be a parent center (which may be part of the Family/Community Service Center if one has been established at the site). Outcomes include specific measures of parent learning and indices of student progress, as well as a general enhancement of the quality of life in the community.

Please indicate all items that apply.

	Yes	**Yes but more of this is needed**	**No**	**If no, is this somethin you want?**
A. Which of the following are available to address specific learning and support needs of the adults in the home?				
1. Does the site offer adult classes focused on				
a. English As a Second Language (ESL)?	___	___	___	___
b. citizenship?	___	___	___	___
c. basic literacy skills?	___	___	___	___
d. GED preparation?	___	___	___	___
e. job preparation?	___	___	___	___
f. citizenship preparation?	___	___	___	___
g. other? (specify) ______________________________	___	___	___	___
2. Are there groups for				
a. mutual support?	___	___	___	___
b. discussion?	___	___	___	___
3. Are adults in the home offered assistance in accessing outside help for personal needs?	___	___	___	___
4. Other? (specify) ______________________________	___	___	___	___
B. Which of the following are available to help those in the home meet their basic obligations to the student?				
1. Is help provided for addressing special family needs for				
a. food?	___	___	___	___
b. clothing?	___	___	___	___
c. shelter?	___	___	___	___
d. health and safety?	___	___	___	___
e. school supplies?	___	___	___	___
f. other? (specify) ______________________________	___	___	___	___

Home Involvement in Schooling (cont.)

	Yes	Yes but more of this is needed	No	If no, is this somethin you want
F. Which of the following are used to enhance home support of student's learning and development?				
1. Are families instructed on how to provide opportunities for students to apply what they are learning?	___	___	___	___
2. Are families instructed on how to use enrichment opportunities to enhance youngsters' social and personal and academic skills and higher order functioning?	___	___	___	___
3. Other? (specify) ________________________	___	___	___	___
G. Which of the following are used to mobilize problem solving at home related to student needs?				
1. Is instruction provided to enhance family problem solving skills(including increased awareness of resources for assistance)?	___	___	___	___
2. Is good problem solving modeled at conferences with the family?	___	___	___	___
3. Other? (specify) ________________________	___	___	___	___
H. Which of the following are used to elicit help from those at home to meet school/community needs? That is, are those in the home recruited and trained to help with				
1. students by				
a. assisting administrators?	___	___	___	___
b. assisting teachers?	___	___	___	___
c. assisting other staff?	___	___	___	___
d. assisting with lessons or tutoring?	___	___	___	___
e. helping on class trips?	___	___	___	___
f. helping in the cafeteria?	___	___	___	___
g. helping in the library?	___	___	___	___
h. helping in computer labs?	___	___	___	___
i. helping with homework helplines?	___	___	___	___
j. working in the front office to welcome visitors and new enrollees and their families?	___	___	___	___
k. phoning home regarding absences?	___	___	___	___
l. outreach to the home?	___	___	___	___
m. other? (specify) ________________________	___	___	___	___

Home Involvement in Schooling (cont.)

	Yes	Yes but more of this is needed	No	If no, is this somethi you wan
2. school operations by assisting with				
a. school and community up-keep and beautification?	___	___	___	___
b. improving school-community relations/	___	___	___	___
c. fund raising?	___	___	___	___
d. PTA?	___	___	___	___
e. enhancing public support by increasing political awareness about the contributions and needs of the school?	___	___	___	___
f. school governance?	___	___	___	___
g. advocacy for school needs?	___	___	___	___
h. advisory councils?	___	___	___	___
i. program planning?	___	___	___	___
j. other? (specify) ______________________	___	___	___	___
3. establishing home-community networks to benefit the community?	___	___	___	___
4. Other? (specify) ______________________	___	___	___	___
I. What programs are used to meet the educational needs of personnel related to this programmatic area?				
1. Is there ongoing training for team members concerned with the area of Home Involvement in Schooling?	___	___	___	___
2. Is there ongoing training for staff of specific services/programs	___	___	___	___
3. Other? (specify) ______________________	___	___	___	___
J. Which of the following topics are covered in educating stakeholders?				
1. designing an inclusionary "Parent Center"	___	___	___	___
2. overcoming barriers to home involvement	___	___	___	___
3. developing group-led mutual support groups	___	___	___	___
4. available curriculum for parent education	___	___	___	___
5. teaching parents to be mentors and leaders at the school	___	___	___	___
6. other (specify) ______________________	___	___	___	___

Home Involvement in Schooling (cont.)

K. Please indicate below any other ways that are used to enhance home involvement in schooling.

L. Please indicate below other things you want the school to do to enhance home involvement in schooling.

Community Outreach for Involvement and Support (including Volunteers)

The emphasis here is on outreaching to the community to build linkages and collaborations, develop greater involvement in schooling, and enhance support for efforts to enable learning. Outreach is made to (a) public and private community agencies, universities, colleges, organizations, and facilities, (b) businesses and professional organizations and groups, and (c) volunteer service programs, organizations, and clubs. If a Family/Parent/ Community Center facility has been established at the site, it can be a context for some of this activity. Anticipated outcomes include measures of enhanced community participation and student progress, as well as a general enhancement of the quality of life in the community.

Please indicate all items that apply.

A. With respect to programs to recruit community involvement and support	**Yes**	**Yes but more of this is needed**	**No**	**If no, is this somethi you wan**
1. From which of the following sources are participants recruited?				
a. public community agencies, organizations, and facilities	___	___	___	___
b. private community agencies, organizations, and facilities	___	___	___	___
c. business sector	___	___	___	___
d. professional organizations and groups	___	___	___	___
e. volunteer service programs, organizations, and clubs	___	___	___	___
f. universities and colleges	___	___	___	___
g. other (specify) ______________________________	___	___	___	___
2. Indicate current types of community involvement at the school				
a. mentoring for students families	___	___	___	___
b. volunteer functions	___	___	___	___
c. a community resource pool that provides expertise as requested, such as				
artists	___	___	___	___
musicians	___	___	___	___
librarians	___	___	___	___
health and safety programs	___	___	___	___
other (specify) ______________________________	___	___	___	___

Community Outreach for Involvement and Support (including Volunteers) [cont.]

	Yes	Yes but more of this is needed	No	If no, is this somethin you want
d. formal agency and program linkages that result in community				
health and social services providers coming to the site	___	___	___	___
after school programs coming to the site services and	___	___	___	___
programs providing direct access to referrals from the	___	___	___	___
site	___	___	___	___
other (specify) ____________________	___	___	___	___
e. formal partnership arrangements that involve community agents in				
school governance	___	___	___	___
advocacy for the school	___	___	___	___
advisory functions	___	___	___	___
program planning	___	___	___	___
fund raising	___	___	___	___
sponsoring activity (e.g., adopt-a-school partners)	___	___	___	___
creating awards and incentives	___	___	___	___
creating jobs	___	___	___	___
other (specify) ____________________	___	___	___	___
B. With specific respect to volunteers				
1. What types of volunteers are used at the site?				
a. nonprofessionals	___	___	___	___
parents	___	___	___	___
college students	___	___	___	___
senior citizens	___	___	___	___
business people	___	___	___	___
peer and cross age tutors	___	___	___	___
peer and cross age counselors	___	___	___	___
paraprofessionals	___	___	___	___
b. professionals-in-training (specify)______________	___	___	___	___
c. professionals (pro bono) (specify)______________	___	___	___	___
d. other (specify) ____________________	___	___	___	___
2. Who do volunteers assist?				
a. administrators	___	___	___	___
b. assist teachers	___	___	___	___
c. assist other staff	___	___	___	___
d. others (specify) ____________________	___	___	___	___

Community Outreach for Involvement and Support (including Volunteers) [cont.]

	Yes	Yes but more of this is needed	No	If no, is this somethi you want?
3. In which of the following ways do volunteers participate?				
a. providing general classroom assistance	___	___	___	___
b. assisting with targeted students	___	___	___	___
c. assisting after school	___	___	___	___
d. providing special tutoring	___	___	___	___
e. helping students with attention problems	___	___	___	___
f. helping with bilingual students	___	___	___	___
g. helping address other diversity matters	___	___	___	___
I helping in the cafeteria	___	___	___	___
j. helping in the library	___	___	___	___
k. helping in computer lab	___	___	___	___
1. helping on class trips	___	___	___	___
m. helping with homework helplines	___	___	___	___
n. working in the front office	___	___	___	___
o. helping welcome visitors	___	___	___	___
p. helping welcome new enrollees and their families	___	___	___	___
q. phoning home about absences	___	___	___	___
r. outreaching to the home	___	___	___	___
s. acting as mentors or advocates for students, families, staff	___	___	___	___
t. assisting with school up-keep and beautification efforts	___	___	___	___
u. helping enhance public support by increasing political awareness about the contributions and needs of the school	___	___	___	___
v. other (specify) ________________________________	___	___	___	___
4. Are there systems and programs specifically designed to				
a. recruit -volunteers?	___	___	___	___
b. train volunteers?	___	___	___	___
c. screen volunteers?	___	___	___	___
d. maintain volunteers?	___	___	___	___
C. Which of the following are used to enhance school involvement of hard to involve students and families (including truants and dropouts and families who have little regular contact with the school)?				
1. home visits to assess and plan ways to overcome barriers to				
a. student attendance	___	___	___	___
b. family involvement in schooling	___	___	___	___
2. support networks connecting hard to involve				
a. students with peers and mentors	___	___	___	___
b. families with peers and mentors	___	___	___	___
3. special incentives for				
a. students	___	___	___	___
b. families	___	___	___	___
4. Other (specify) ______________________________	___	___	___	___

Community Outreach for Involvement and Support (including Volunteers) [cont.]

	Yes	**Yes but more of this is needed**	**No**	**If no, is this somethin you wan**
D. Which of the following are used to enhance community-school connections and sense of community?				
1. orientations and open houses for				
a. newly arriving students	___	___	___	___
b. newly arriving families	___	___	___	___
c. new staff	___	___	___	___
2. student performances for the community	___	___	___	___
3. school sponsored				
a. cultural and sports events for the community	___	___	___	___
b. community festivals and celebrations	___	___	___	___
c. topical workshops and discussion groups	___	___	___	___
d. health fairs	___	___	___	___
e. family preservation fairs	___	___	___	___
f. work fairs	___	___	___	___
4. Other? (specify) ______________________________	___	___	___	___
E. What programs are used to meet the educational needs of personnel related to this programmatic area?				
1. Is there ongoing training for team members concerned with the area of Community Outreach/Volunteer?	___	___	___	___
2. Is there ongoing training for staff of specific services/programs?	___	___	___	___
3. Other? (specify) ______________________________	___	___	___	___
F. Which of the following topics are covered in educating stakeholders?				
1. understanding the local community -- culture, needs, resources	___	___	___	___
2. how to recruit, train, and retain volunteers				
a. in general	___	___	___	___
b. for special roles	___	___	___	___
3. how to move toward collaborations with community resources	___	___	___	___
4. how to outreach to hard-to-involve students and families	___	___	___	___
5. other (specify) ______________________________	___	___	___	___

Community Outreach for Involvement and Support (including Volunteers) [cont.]

G. Please indicate below any other ways that are used with respect to community outreach/ volunteer programs.

H. Please indicate below other things you want the school to do with respect to community outreach/volunteer programs.

Developing a Resource Coordinating Team

Creation of a School-site Resource Coordinating *Team* provides a good starting place in efforts to enhance coordination and integration of services and programs. Such a team not only can begin the process of transforming what is already available, it can help reach out to District and community resources to enhance enabling activity.

A Resource Coordinating Team differs from Student Study and Guidance Teams. The focus of a Resource Coordinating Team is not on individual students. Rather, it is oriented to clarifying resources and how they are best used. That is, it provides a necessary mechanism for enhancing *systems* for communication and coordination.

For many support service personnel, their past experiences of working in isolation -- and in competition -- make this collaborative opportunity unusual and one which requires that they learn new ways of relating and functioning. For those concerned with school restructuring, establishment of such a team is one facet of efforts designed to restructure school support services in ways that (a) integrates them with school-based/linked support programs, special projects, and teams and (b) outreaches and links up with community health and social service resources.

Purposes

Such a team exemplifies the type of on-site organizational mechanism needed for overall cohesion and coordination of school support programs for students and families. Minimally, such a team can reduce fragmentation and enhance cost-efficacy by assisting in ways that encourage programs to function in a coordinated and increasingly integrated way. For example, the team can develop communication among school staff and to the home about available assistance and referral processes, coordinate resources, and monitor programs to be certain they are functioning effectively and efficiently. More generally, this group can provide leadership in guiding school personnel and clientele in evolving the school's vision for its support program (e.g., as not only preventing and correcting learning, behavior, emotional, and health problems but as contributing to classroom efforts to foster academic, social, emotional, and physical functioning). The group also can help to identify ways to improve existing resources and acquire additional ones.

Major examples of the group's activity are

- preparing and circulating a list profiling available resources (programs, personnel, special projects, services, agencies) at the school, in the district, and in the community
- clarifying how school staff and families can access them
- refining and clarifying referral, triage, and case management processes to ensure resources are used appropriately (e.g., where needed most, in keeping with the principle of adopting the least intervention needed, with support for referral follow-through)
- mediating problems related to resource allocation and scheduling,
- ensuring sharing, coordination, and maintenance of needed resources,
- exploring ways to improve and augment existing resources to ensure a wider range are available (including encouraging preventive approaches, developing linkages with other district and community programs, and facilitating relevant staff development)
- evolving a site's enabling activity infrastructure by assisting in creation of area program teams and Family/Parent Centers as hubs for enabling activity

(cont.)

Developing a Resource Coordinating Team (cont.)

Membership

Team membership typically includes representatives of all activity designed to support a school's teaching efforts (e.g., a school psychologist, nurse, counselor, social worker, key special education staff, etc.), along with someone representing the governance body (e.g., a site administrator such as an assistant principal). Also, included are representatives of community agencies already connected with the school, with others invited to join the team as they became involved.

The team meets as needed. Initially, this may mean once a week. Later, when meetings are scheduled for every 2-3 weeks, continuity and momentum are maintained through interim tasks performed by individuals or subgroups. Because some participants are at a school on a part-time basis, one of the problems that must be addressed is that of rescheduling personnel so that there is an overlapping time for meeting together. Of course, the reality is that not all team members will be able to attend every meeting, but a good approximation can be made at each meeting, with steps taken to keep others informed as to what was done.

Examples of Resource Coordination Team Initial and Ongoing Tasks

- Orientation for representatives to introduce each to the other and provide further clarity of Team's purposes and processes

- Review membership to determine if any group or major program is not represented; take steps to assure proper representation

- Share information regarding what exists at the site (programs, services, systems for triage, referral, case management)

- Share information about other resources at complex schools and in the immediate community and in the cluster and district-wide

- Analyze information on resources to identify important needs at the site

- Establish priorities for efforts to enhance resources and systems

- Formulate plans for pursuing priorities

- Discussion of the need to coordinate crisis response across the complex and to share complex resources for site specific crises (with conclusions to be share at Complex Resource Coordinating Council)

- Discussion of staff (and other stakeholder) development activity

- Discussion of quality improvement and longer-term planning (e.g., efficacy, pooling of resources)

General meeting format

- Updating on and introduction of team membership
- Reports from those who had between meeting assignments
- Current topic for discussion and planning
- Decision regarding between meeting assignments
- Ideas for next agenda

Developing a Complex (Multisite) Resource Coordinating Council

Schools in the same geographic (catchment) area have a number of shared concerns, and feeder schools often are interacting with the same family. Furthermore, some programs and personnel are (or can be) shared by several neighboring schools, thus minimizing redundancy and reducing costs.

Purpose

In general, a group of sites can benefit from having a Resource Coordinating *Council* as an ongoing mechanism that provides leadership, facilitates communication, and focuses on coordination, integration, and quality improvement of whatever range of activity the sites has for enabling activity.

Some specific functions are

- To share information about resource availability (at participating schools and in the immediate community and in geographically related schools and district-wide) with a view to enhancing coordination and integration
- To identify specific needs and problems and explore ways to address them (e.g., Can some needs e met by pooling certain resources? Can improved linkages and collaborations be created with community agencies? Can additional resources be acquired? Can some staff and other stakeholder development activity be combined?)
- To discuss and formulate longer-term plans and advocate for appropriate resource allocation related to enabling activities.

Membership

Each school can be represented on the *Council* by two members of its Resource *Team*. To assure a broad perspective, one of the two can be the site administrator responsible for enabling activity; the other can represent line staff.

Facilitation

Council facilitation involves responsibility for convening regular monthly (and other ad hoc) meetings, building the agenda, assuring that meetings stay task focused and that between meeting assignments will be carried out, and ensuring meeting summaries are circulated.

With a view to shared leadership and effective advocacy, an administrative leader and a council member elected by the group can co-facilitate meetings. Meetings can be rotated among schools to enhance understanding of each site in the council.

Location

Meeting at each school on a rotating basis can enhance understanding of the complex.

(cont.)

Developing a Complex (Multisite) Resource Coordinating Council (cont.)

Steps in Establishing a Complex Coordinating Council

a. Informing potential members about the Council's purpose and organization (e.g., functions, representation, time commitment).

Accomplished through presentation and handouts.

b. Selection of representatives.

Chosen at a meeting of a school's Resource Coordinating Team. (If there is not yet an operational Team, the school's governance can choose acting representatives.)

c. Task focus of initial meetings

- Orient representatives to introduce each to the other and provide further clarity of Council's purposes and processes
- Review membership to determine if any group or major program is not represented; take steps to assure proper representation
- Share information regarding what exists at each site
- Share information about other resources at complex schools and in the immediate community and in the cluster and district-wide
- Analyze information on resources to identify important needs at specific sites and for the complex as a whole
- Establish priorities for efforts to enhance resources
- Formulate plans for pursuing priorities
- Discuss plan for coordinated crisis response across the complex and sharing of resources for site specific crises
- Discuss combined staff (and other stakeholder) development activity
- Discuss (and possibly visit) school-based centers (Family Service Center, Parent Center) with a view to best approach for the complex
- Discuss quality improvement and longer-term planning (e.g., efficacy, pooling of resources)

d. General meeting format

- Updating on and introduction of council membership
- Reports from those who had between meeting assignments
- Current topic for discussion and planning
- Decision regarding between meeting assignments
- Ideas for next agenda

A Few Related References

State financing strategies that promote more effective services for children and families. F. Farrow (1991). In: *Effective services for young children: Report of a workshop.* L. B. Schorr, D. Both, & C. Copple (Eds.). Washington, DC: National Academy Press.

Health Insurance for Children: State and Private Programs Create New Strategies to Insure Children. Government Accounting Office. GAO/HEHS-96-35, 1996.

Summary of selected funding sources for school-based services. E.R. Dunn-Malhotra & A. Shotton (1990). Document prepared for Urban Strategies Council. Available from Youth Law Center, 114 Sansome Street, Suite 950, San Francisco CA 94104-3820.

Financing strategies to support innovations in services delivery to children. J. Meyers (1994). *Journal of Clinical Child Psychology,* 23(Suppl.), 48-54.

State initiatives to provide medical coverage for uninsured children. C. DeGraw, M.J. Park, J.A. Hudman (1995). *The Future of Children,* 5(1), 223-231.

Legal, professional, and financial constraints on psychologists' delivery of health care services in school settings. S. T. DeMers, P. Bricklin (1995). *School Psychology Quarterly, 10,* 217-235.

School-based health centers and managed care health plans: Partners in primary care. D.J. Zimmerman & C.J. Reif (1995). *Journal of Public Health Management Practice,* 1(1), 33-39.

Issues in financing school-based health centers: A guide for state officials. Document prepared by Making the Grade (1995). Available from The George Washington University, Washington, DC.

Potential sources of federal support for school-based and school linked health services. J. Steinschneider (1993). *Education and Urban Society,* 25(2), 166-74.

Full-service schools: A revolution in health and social services for children, youth, and families. J.G. Dryfoos (1994). San Francisco: Jossey-Bass.

The politics of linking schools and social services L. Adler & S. Gardner (Eds.) (1994). Washington, D.C.: Falmer Press.

Working Together in Schools – A Guide for Educators G.A. Donaldson Jr. & D.R. Sanderson (1996). Thousand Oaks, CA: Sage.

School/Family/Community Partnerships: Caring for the Children We Share. J.L. Epstein (1995). *Phi Delta Kappan,* 76(9), 701-713.

Collaboration Skills for School Professionals (2nd ed.) M. Friend & L. Cook (1996). National Professional Resources, Inc.

School Social Workers, Counselors, and Psychologists in Collaboration: A Shared Agenda. M. Gibelman (1993). *Social Work in Education, 15,* 45-53.

The same client: The demographics of education and service delivery systems. H.L. Hodgkinson (1989). Washington, DC: Institute for Educational Leadership. Inc./Center for Demographic Policy.

Serving Children, Youth and Families Through Interprofessional Collaboration and Service Integration: A Framework for Action.
K. Hooper-Briar & H.A. Lawson (1994). Oxford, OH: The Danforth Foundation and the Institute for Educational Renewal at Miami University.

Expanding Partnerships for Vulnerable Children, Youth, and Families
K. Hooper-Briar & H.A. Lawson (Eds.) (1996). Alexandria, VA: Council on Social Work Education

Multidisciplinary Teams Revisited: Current Perceptions of School Psychologists Regarding Team Functioning.
E.S. Huebner and K. Gould (1991). *School Psychology Review*, 20, 428-434.

How shall we study comprehensive collaborative services for children and families?
M.S. Knapp (1995). *Educational Researcher*, 24, 5-16.

Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets (3rd ed.)
J.P. Kretzmann & J.L. McKnight (1993). Chicago, IL: ACTA Publications.

Best Practices in Considering the Role of Culture.
G. S. Mosley-Howard (1995). In A. Thomas and J. Grimes (Eds.) *Best Practices in School Psychology III*. Washington DC: The National Association of School Psychologists.

Activities for Teams.
F. Rees (1993). San Diego, CA: Pfeiffer & Co.

Turf Wars: Moving from Competition to Collaboration.
H. Robbins (1990). Glenview, IL. Scott, Foresman and Co.

Instructional Consultation Teams Collaborating for Change.
S.A. Rosenfield & T.A. Gravois (1996). New York: The Guilford Press.

Upgrading School Support Programs through Collaboration: Resource Coordinating Teams.
L. Rosenblum, M. DiCecco, L. Taylor, and H. Adelman (1995). *Social Work in Education, 17*, 117-124.

Fostering school/community relationships. S.M. Sheridan (1995). In *Best practices in school psychology – III*. A. Thomas & J. Grimes (Eds.). Washington, DC: National Association for School Psychologists

Community collaboration: If it is such a good idea, why is it so hard to do?
J.A. White & G. Wehlage (1995). *Educational Evaluation and Policy Analysis*, 17, 23-38.

Developing Integrated Services for Children and Families: a Cross-Disciplinary Approach.
C. Zuniga-Hill and J.B. George (1995). *Journal of Teacher Education, 46*, 101-108.

MENTAL HEALTH AND SCHOOL-BASED HEALTH CENTERS

Module II

Working with Students Who Come to the Center

> *Deciding what is best for a child often poses a question no less ultimate than the purposes and values of life itself.*
>
> Robert Mnookin

When it comes to mental health and psychosocial problems, a SBHC's staff doesn't have to look very hard to find them. Because they are inundated with students who need assistance for mental health and psychosocial concerns, key services many centers find themselves providing are the *identification and processing* of such students. Major tasks in carrying out these services are initial problem identification, triage, screening/assessment, client consultation and referral and related follow-up.

Beyond identifying and processing students, SBHCs can foster preferral interventions, provide psychosocial guidance and support (related to classroom and individual needs), offer a small number of students psychosocial counseling, and when feasible, *establish ongoing case monitoring/management*. With an eye to *primary prevention*, some even are involved in mental health education. And all center staff need to be prepared to join others at a school site in *responding to students' psychological crises*.

Units:

Overview
A. Consent, Due Process, and Confidentiality
B. Problem Identification, Prereferral Intervention,
    and Consultation with School Staff
C. Screening/Assessment
D. Client Consultation and Referral
E. Respondng to Student's Ongoing Psychosocial
    and Mental Health Needs
F. Responding to Crisis at a School
G. Management of Care and Follow-up Evaluation (Case Management)

Module II

Working with Students Who Come to the Center

Contents

Page

OVERVIEW II-1

UNIT IIA
Consent, Due Process, and Confidentiality IIA-1
- Consent and Due Process IIA-2
- Confidentiality and Privacy IIA-5

Resource Aids IIA-10

UNIT IIB
Problem Identification, Prereferral Intervention, and Consultation with School Staff
- Initial Problem Identification
- Prereferral Interventions
- Staff Consultation

Resource Aids

UNIT IIC
Screening/Assessment
- More than Identifying a Problem
- A Few Procedural Guidelines and Specific Topics to Explore

Resource Aids

UNIT IID
Client Consultation and Referral

- More than Giving a Name and Address
- The Referral Process: Some Guidelines and Steps
- Providing Information about Programs and Services
- Developing Ways to Facilitate Access to Resources
- Follow-Up on Referrals (including Consumer Feedback)

Resource Aids

UNIT IIE
Responding to Students' Ongoing Psychosocial and Mental Health Needs

- Psychosocial Guidance and Support
- Psychosocial Counseling
- Prevention/Mental Health Education

Resource Aids

UNIT IIF
Responding to Crises at a School

- School-Based Crisis Intervention: Overview
- Psychological First Aid
- Addressing Specific Areas of Concern Related to Crises

Resource Aids

UNIT IIG
Management of Care & Follow-up Evaluation (Case Management)

- Initial Monitoring of Care
- Ongoing Monitoring/Management of Care

Resource Aids

A Few Related Resources

Appendix II-1: Connecting the Student with the Right Help

Appendix II-2: About the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)

Appendix II-3: Organizing and Training a School-Based Crisis Team

Appendix II-4: Addressing Specific Areas of Concern Related to Crises

Exhibits and Resource Aids in Module II

Exhibits

Page

Overview

10. Direct Interventions II-6
11. Intervention Flow Chart II-7
12. Matters for a School to Consider in Developing its Systems for Problem Identification, Triage, Referral, and Case Management II-8
13. Steps in Meeting Students' Needs II-9

Unit IIA

14. Some Due Process Safeguards IIA-3

Unit IIB

15. A Guide for Teachers and Other School Staff Regarding the Prereferral Process
16. Building Rapport and Connection

Unit IIC

17. A Basic Interview Format
18. Outline of Specific Areas and Topics that Might Be Explored to Better Understand the Nature and Scope of Problems

Unit IID

19. Referral Intervention Guidelines and Steps

Unit IIE

20. A Few Thoughts About Engaging Students in a Productive Dialogue
21. Some Points About Counseling and Student Motivation

Unit IIF

22. Scope of Crisis Events and Intervention Phases
23. Major Facets of Crises Response
24. A Few General Principles Related to Responding to Crises

Resource Aids

Unit IIA

IIA-1 School Based Health Center Informed Consent Form IIA-11
IIA-2 Consent to Exchange Confidential Information IIA-14

Unit IIB

IIB-1 A Guide for Teachers and Other School Staff Regarding the Prereferral Process
IIB-2 Building Rapport and Connection

Unit IIC

IIC-1 A Basic Interview Format
IIC-2 Outline of Specific Areas and Topics that Might Be Explored to Better Understand the Nature and Scope of Problems
IIC-3 Substance Abuse Checklist

Unit IID

IID-1 Referral Intervention Guidelines and Steps

Unit IIE

IIE-1 A Few Thoughts About Engaging Students in a Productive Dialogue
IIE-2 Some Points About Counseling and Student Motivation

Unit IIF

IIF-1 Scope of Crisis Events and Intervention Phases
IIF-2 Major Facets of Crises Response
IIF-3 A Few General Principles Related to Responding to Crises

Overview

Before discussing intervention, it is relevant to think about differentiating psychopathology from psychosocial problems.

The following is a way to think about the implications of a broad framework for understanding the causes of students' problems. This way of thinking offers a useful *starting* place for classifying behavioral, emotional, and learning problems and helps avoid overdiagnosing internal pathology.

> As illustrated below, such problems can be differentiated along a continuum that separates those caused by internal factors, environmental variables, or a combination of both.

Problems Categorized on a Continuum Using a Transactional View of the Primary Locus of Cause

Problems caused by factors in the environment (E)		Problems caused equally by environment and person		Problems caused by factors in the the person (P)
E	(E<--->p)	E<--->P	(e<--->P)	P
Type I problems		Type II problems		Type III problems
•caused primarily by environments and systems that are deficient and/or hostile		•caused primarily by a significant *mismatch* between individual differences and vulnerabilities and the nature of that person's environment (not by a person's pathology)		•caused primarily by person factors of a pathological nature
•problems are mild to moderately severe and narrow to moderately pervasive		•problems are mild to moderately severe and pervasive		•problems are moderate to profoundly severe and moderate to broadly pervasive

In this conceptual scheme, the emphasis in each case is on problems that are beyond the early stage of onset.

To highlight a few points about the illustration:

- Problems caused by the environment are placed at one end of the continuum and referred to as *Type I problems.*
- At the other end are problems caused primarily by pathology within the person; these are designated as *Type III problems.*
- In the middle are problems stemming from a relatively equal contribution of environmental and person sources, labelled *Type II problems.*

Also note that in this scheme, diagnostic labels denoting *extremely* dysfunctional problems *caused by pathological conditions within a person* are reserved for individuals who fit the Type III category.

> Obviously, some problems caused by pathological conditions within a person are not manifested in severe, pervasive ways, and there are persons without such pathology whose problems do become severe and pervasive. The intent is not to ignore these individuals. As a first categorization step, however, it is essential they not be confused with those seen as having Type III problems.

At the other end of the continuum are individuals with problems arising from factors outside the person (i.e., Type I problems). Many people grow up in impoverished and hostile environmental circumstances. Such conditions should be considered first in hypothesizing what *initially* caused the individual's behavioral, emotional, and learning problems. (After environmental causes are ruled out, hypotheses about internal pathology become more viable.)

To provide a reference point in the middle of the continuum, a Type II category is used. This group consists of persons who do not function well in situations where their individual differences and minor vulnerabilities are poorly accommodated or are responded to hostilely. The problems of an individual in this group are a relatively equal product of person characteristics and failure of the environment to accommodate that individual.

> There are, of course, variations along the continuum that do not precisely fit a category. That is, at each point between the extreme ends, environment-person transactions are the cause, but the degree to which each contributes to the problem varies. Toward the environment end of the continuum, environmental factors play a bigger role (represented as E<--->p). Toward the other end, person variables account for more of the problem (thus e<--->P).

Outlined below is an aid for thinking about causes of learning, behavior, and emotional problems.

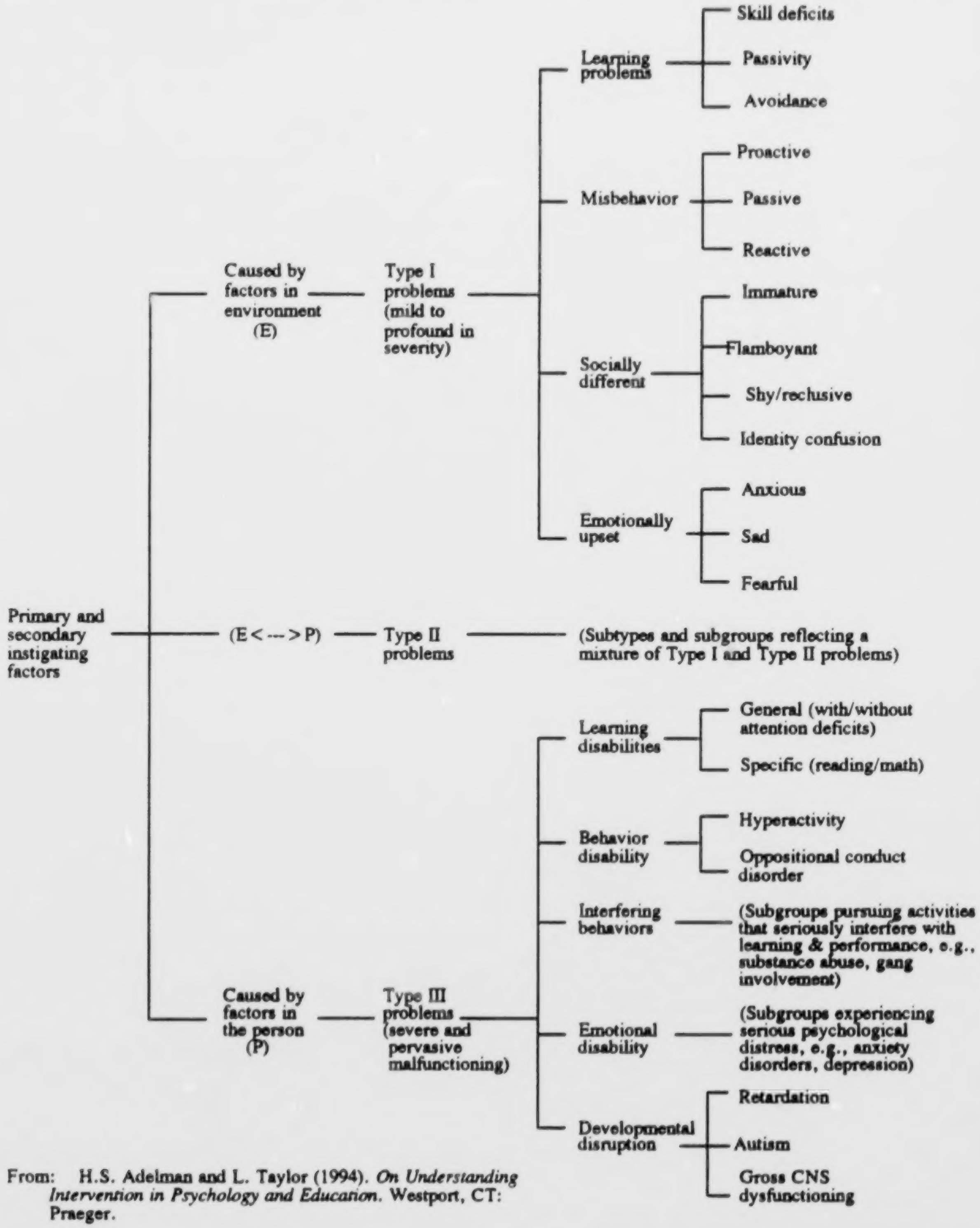
Factors Instigating Emotional, Behavioral, and Learning Problems

Environment (E) (Type I problem)	*Person (P)* (Type III problems)	*Interactions and Transactions Between E and P** (Type II problems)
1. Insufficient stimuli (e.g.,prolonged periods in impoverished environments; deprivation of learning opportunities at home or school such as lack of play and practice situations and poor instruction; inadequate diet)	1. Physiological insult (e.g., cerebral trauma, such as accident or stroke, endocrine dysfunctions and chemical imbalances; illness affecting brain or sensory functioning)	1. Severe to moderate personal vulnerabilities and environmental defects and differences (e.g., person with extremely slow development in a highly demanding environment, all of which simultaneously and equally instigate the problem)
2. Excessive stimuli (e.g., overly demanding home, school, or work experiences, such as overwhelming pressure to achieve and contradictory expectations; overcrowding)	2. Genetic anomaly (e.g., genes which limit, slow down, or lead to any atypical development)	2. *Minor* personal vulnerabilities not accommodated by the situation (e.g., person with minimal CNS disorders resulting in auditory perceptual disability trying to do auditory-loaded tasks; very active person forced into situations at home, school, or work that do not tolerate this level of activity)
3. Intrusive and hostile stimuli (e.g., medical practices, especially at birth, leading to physiological impairment; contaminated environments; conflict in home, school, workplace; faulty child-rearing practices, such as long-standing abuse and rejection; dysfunctional family; migratory family; language used is a second language; social prejudices related to race, sex, age, physical characteristics and behavior)	3. Cognitive activity and affective states experienced by self as deviant (e.g., lack of knowledge or skills such as basic cognitive strategies; lack of ability to cope effectively with emotions, such as low self-esteem)	3. Minor environmental defects and differences not accommodated by the individual (e.g., person is in the minority racially or culturally and is not participating in many social activities because he or she thinks others may be unreceptive)
	4. Physical characteristics shaping contact with environment and/or experienced by self as deviant (e.g., visual, auditory, or motoric deficits; excessive or reduced sensitivity to stimuli; easily fatigued; factors such as race, sex, age, or unusual appearance that produce stereotypical responses)	
	5. Deviant actions of the individual (e.g., performance problems, such as excessive errors in performing; high or low levels of activity)	

*May involve only one (P) and one (E) variable or may involve multiple combinations.

From: H.S. Adelman and L. Taylor (1993). *Learning problems and learning disabilities: Moving forward*. Pacific Grove, CA: Brooks/Cole. Reprinted with permission.

The following diagram uses an understanding of person, environment, and interactional causes to outline and differentiate among the types of problems seen among students.


Primary and secondary instigating factors
Caused by factors in environment (E)
Type I problems (mild to profound in severity)
Learning problems
Skill deficits
Passivity
Avoidance
Misbehavior
Proactive
Passive
Reactive
Socially different
Immature
Flamboyant
Shy/reclusive
Identity confusion
Emotionally upset
Anxious
Sad
Fearful
(E<--->P)
Type II problems
(Subtypes and subgroups reflecting a mixture of Type I and Type II problems)
Caused by factors in the person (P)
Type III problems (severe and pervasive malfunctioning)
Learning disabilities
General (with/without attention deficits)
Specific (reading/math)
Behavior disability
Hyperactivity
Oppositional conduct disorder
Interfering behaviors
(Subgroups pursuing activities that seriously interfere with learning & performance, e.g., substance abuse, gang involvement)
Emotional disability
(Subgroups experiencing serious psychological distress, e.g., anxiety disorders, depression)
Developmental disruption
Retardation
Autism
Gross CNS dysfunctioning

From: H.S. Adelman and L. Taylor (1994). *On Understanding Intervention in Psychology and Education*. Westport, CT: Praeger.

On the following pages are several exhibits designed to provide an overview of matters discussed in this unit. They cover activities, processes, and other matters to be considered as a School Based Health Center and the school as a whole develop programs and systems for direct service and instruction related to mental health and psychosocial concerns. In reviewing these exhibits, note the many decision points that arise and the various stakeholders who are involved.

The identification process involves center and school staff, students, and parents. Educating all concerned about the nature of psychosocial and mental health problems and prevention and about available resources is a major task related to problem identification.

Once a problem is identified, the matter of consent to use the health center is decided -- in keeping with legal and district policies. Those without consent still need to be screened, but by school-district personnel. Hopefully, some district staff also are available to provide school-based or linked services for such students as necessary.

Initial case monitoring begins as soon as a student is identified as needing assistance. Monitoring continues to ensure proper assistance is provided directly at school or by a resource to which the student is referred. Ongoing case monitoring and follow-up evaluations are designed to check on the appropriateness and effectiveness of assistance provided. It must be anticipated that the first forms of assistance often do not work out and that case monitoring and evaluation are a natural and essential part of ensuring that students are properly helped.

Exhibit 10. Direct Interventions

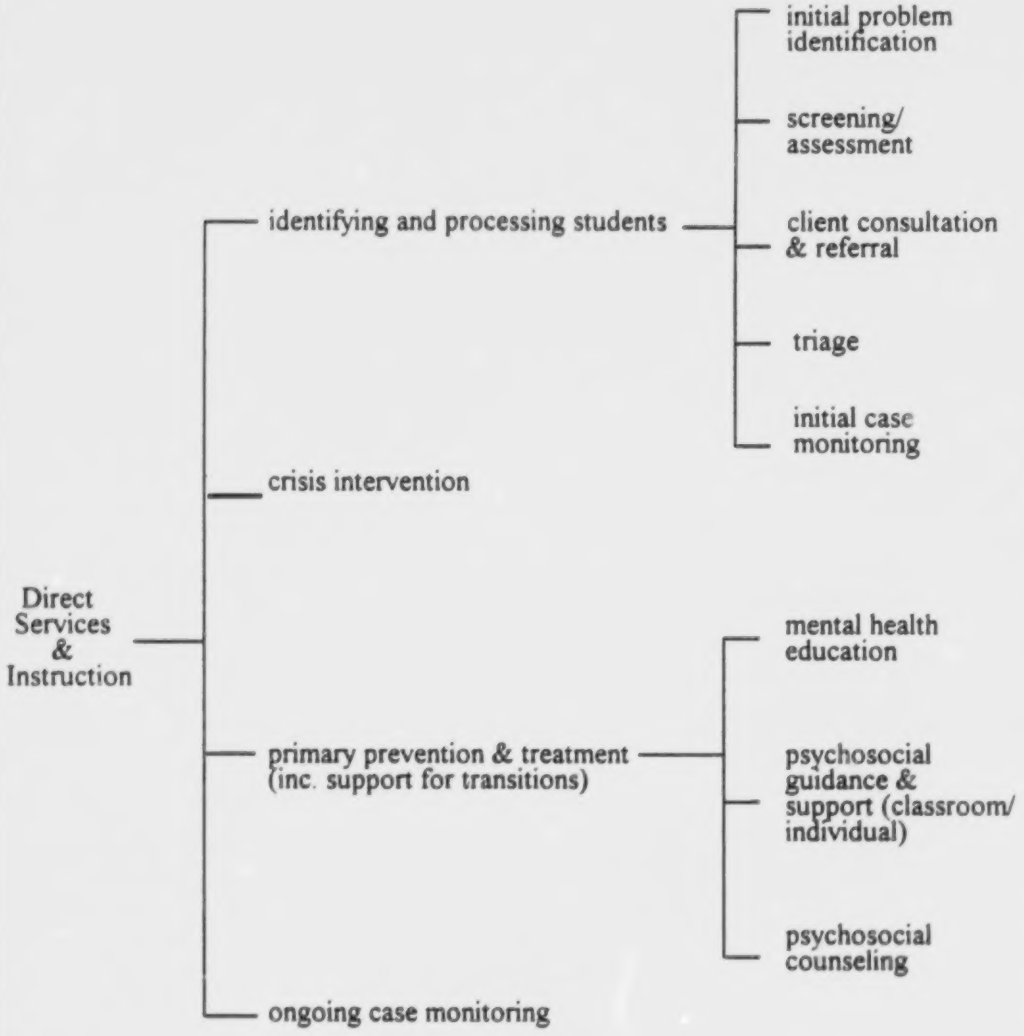
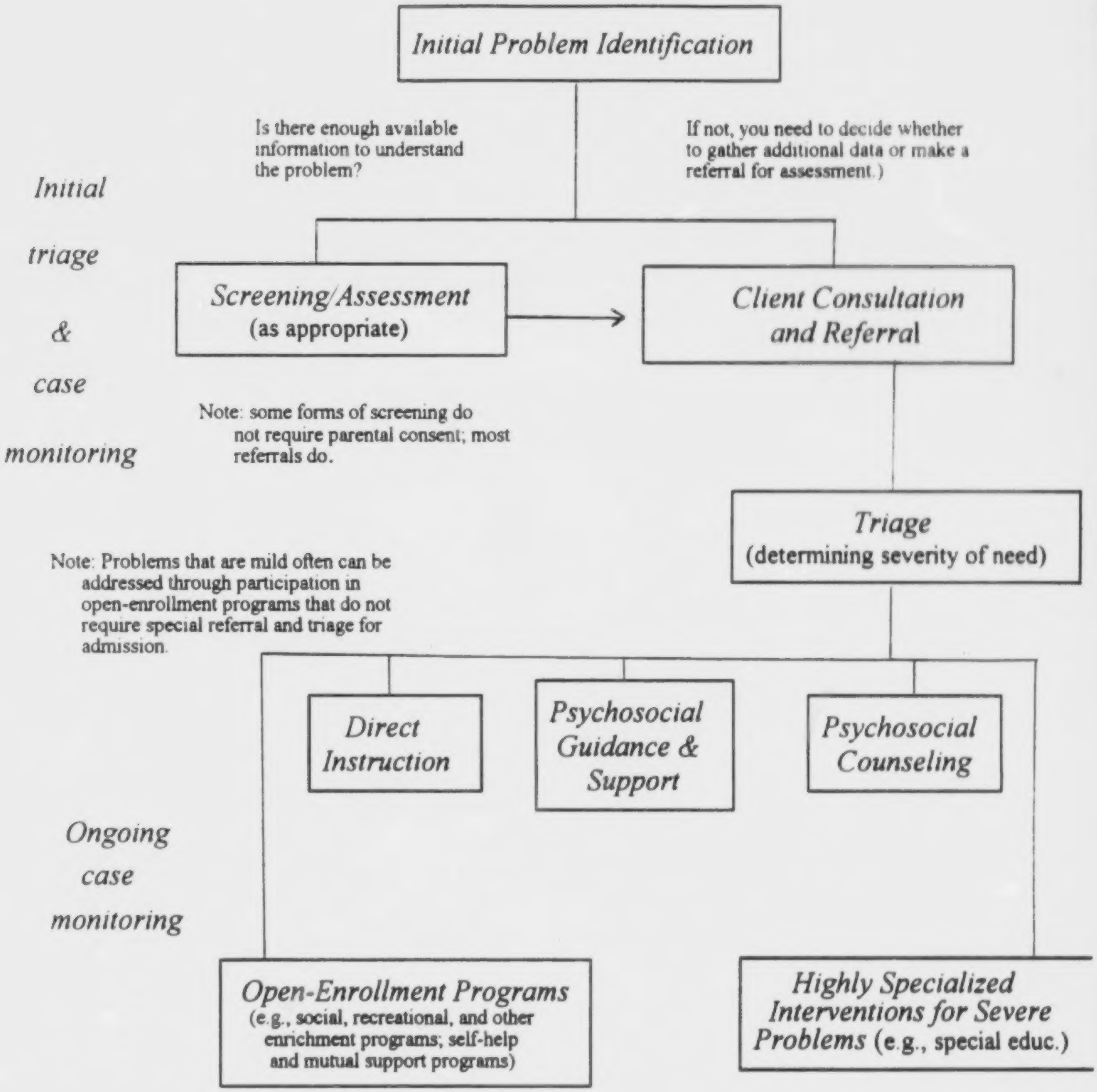

Direct Services & Instruction
identifying and processing students
initial problem identification
screening/ assessment
client consultation & referral
triage
initial case monitoring
crisis intervention
primary prevention & treatment (inc. support for transitions)
mental health education
psychosocial guidance & support (classroom/ individual)
psychosocial counseling
ongoing case monitoring

Exhibit 11. Intervention Flow Chart


Initial Problem Identification
Is there enough available information to understand the problem?
If not, you need to decide whether to gather additional data or make a referral for assessment.)
Initial triage & case monitoring
Screening/Assessment (as appropriate)
Client Consultation and Referral
Triage (determining severity of need)
Direct Instruction
Psychosocial Guidance & Support
Psychosocial Counseling
Ongoing case monitoring
Open-Enrollment Programs (e.g., social, recreational, and other enrichment programs; self-help and mutual support programs)
Highly Specialized Interventions for Severe Problems (e.g., special educ.)

Note: some forms of screening do not require parental consent; most referrals do.

Note: Problems that are mild often can be addressed through participation in open-enrollment programs that do not require special referral and triage for admission.

Exhibit 12. Matters for a School to Consider in Developing its Systems for Problem Identification, Triage, Referral, and Case Management

Problem identification

(a) Problems may be identified by anyone (staff, parent, student).
(b) There should be an Identification Form that anyone can access and fill out.
(c) There must be an easily accessible place for people to turn in forms.
(d) All stakeholders must be informed regarding the availability of forms, where to turn them in, and what will happen after they do so.

Triage processing

(a) Each day the submitted forms must be reviewed, sorted, and directed to appropriate resources by a designated and trained triage processor. Several individuals can share this task; for example, different persons can do it on a specific day or for specified weeks.
(b) After the sorting is done, the triage processor should send a Status Information Form to the person who identified the problem (assuming it was not a self-referral).

Clients directed to resources or for further problem analysis and recommendations

(a) For basic necessities of daily living (e.g., food, clothing, etc.), the triage processor should provide information about resources either through the person who identified the problem or directly to the student/family in need.
(b) If the problem requires a few sessions of immediate counseling to help a student/ family through a crisis, the triage processor should send the form to the person who makes assignments to on-site counselors.
(c) The forms for all others are directed to a small triage "team" (1-3 trained professionals) for further analysis and recommendations. (If there is a large case load, several teams might be put into operation.) Members of such a team may not have to meet on all cases; some could be reviewed independently with recommendations made and passed on the next reviewer for validation. In complex cases, however, not only might a team meeting be indicated, it may be necessary to gather more information from involved parties (e.g., teacher, parent, student).

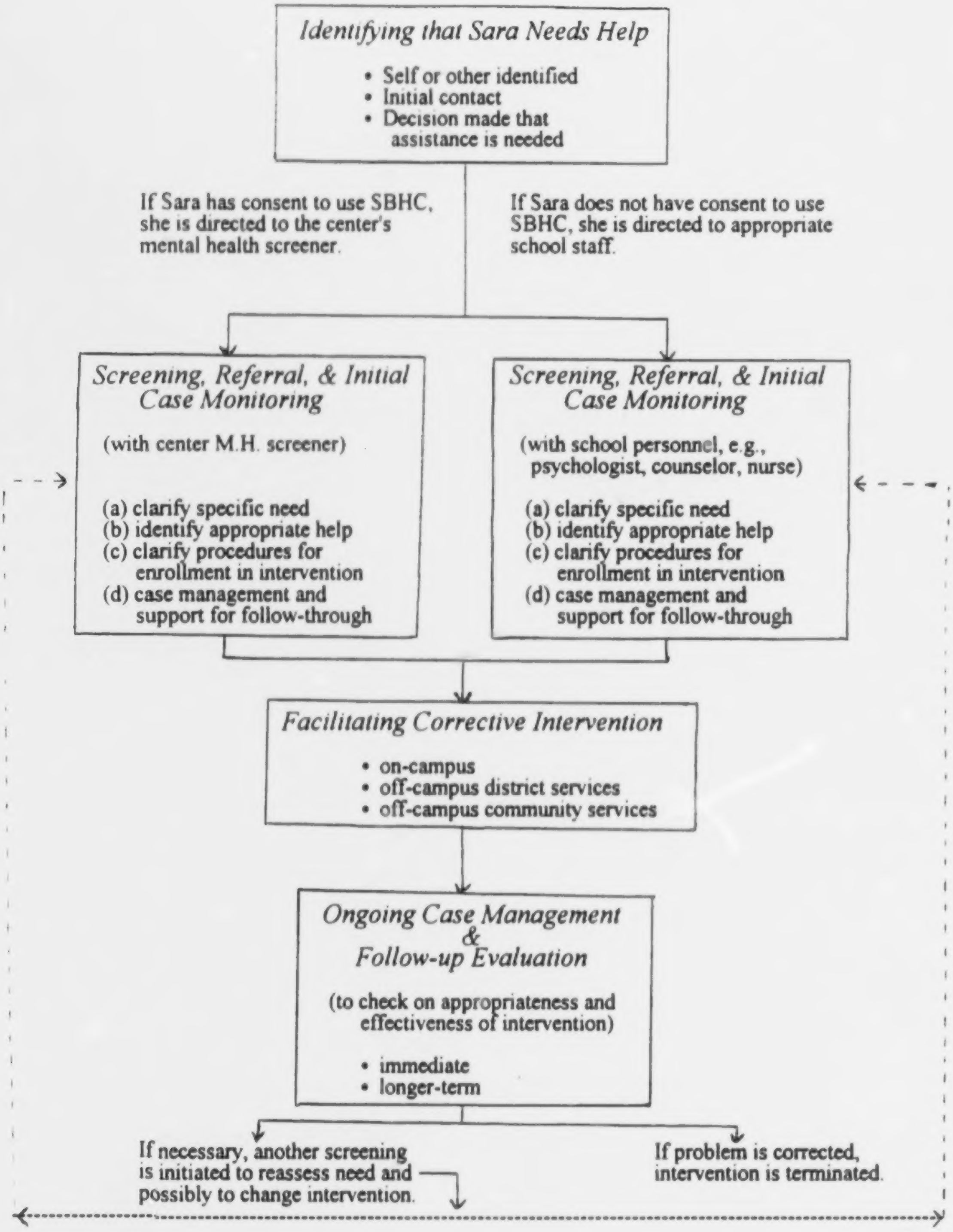
Interventions to ensure recommendations and referrals are pursued appropriately

(a) In many cases, prereferral interventions should be recommended. This means a site must be equipped to implement and monitor the impact of such recommendations.
(b) When students/families are referred for health and social services, procedures should be established to facilitate motivation and ability for follow-through. Case management should be designed to determine follow-through, coordination, impact, and possible need for additional referrals.
(c) Referrals to assess the need for special or compensatory education often are delayed because of a waiting list. Back logs should be monitored and arrangements made to catch-up (e.g., by organizing enough released time to do the assessments and case reviews).

Case monitoring/management

(a) Some situations require only a limited form of case monitoring (e.g., to ensure follow-through). A system must be developed for assigning case monitors as needed. Aides and paraprofessionals often can be trained to for this function.
(b) Other situations require intensive management by specially trained professionals to (a) ensure interventions are coordinated/integrated and appropriate, (b) continue problem analysis and determine whether appropriate progress is made, (c) determine whether additional assistance is needed, and so forth. There are many models for intensive case management. For example, one common approach is to assign the responsibility to the professional who has the greatest involvement (or best relationship) with the student/family.
(c) One key and often neglected function of the case monitor/manager is to provide appropriate status updates to all parties who should be kept informed.

Exhibit 13. Steps in Meeting a Student's Needs


Identifying that Sara Needs Help
• Self or other identified
• Initial contact
• Decision made that assistance is needed
If Sara has consent to use SBHC, she is directed to the center's mental health screener.
If Sara does not have consent to use SBHC, she is directed to appropriate school staff.
Screening, Referral, & Initial Case Monitoring
(with center M.H. screener)
(a) clarify specific need
(b) identify appropriate help
(c) clarify procedures for enrollment in intervention
(d) case management and support for follow-through
Screening, Referral, & Initial Case Monitoring
(with school personnel, e.g., psychologist, counselor, nurse)
(a) clarify specific need
(b) identify appropriate help
(c) clarify procedures for enrollment in intervention
(d) case management and support for follow-through
Facilitating Corrective Intervention
• on-campus
• off-campus district services
• off-campus community services
Ongoing Case Management & Follow-up Evaluation
(to check on appropriateness and effectiveness of intervention)
• immediate
• longer-term
If necessary, another screening is initiated to reassess need and possibly to change intervention.
If problem is corrected, intervention is terminated.

Unit IIA
Consent, Due Process, and Confidentiality

"Clearly, confidentiality mandates are very important and they need to be upheld. They have been developed to protect basic rights to privacy which all service providers must closely guard and carefully respect. Also, It must be recognized that in addition to governmental legal requirements, most professional disciplines have legal obligations or strong ethical standards that prohibit release of information about a client, patient, or student without consent.

> Confidentiality requirements involving interagency collaboration certainly are not new. ...what is new is that in the current environment there exists a growing expectation that organizations routinely will work together to help children and families. Put into practice, this expectation has several implications in the area of information sharing: it means that an exchange of information is likely to be sought in substantially more cases, that more organizations are likely to be involved in the exchange, and that more detailed information is likely to be desired. In brief, questions that once were rarely asked about vulnerable children and families are now far more likely to be commonplace.

As interagency collaboration efforts gain momentum, service providers from education, mental health, child welfare, and health agencies increasingly find themselves in a very delicate *dilemma.*"

William Davis, 1994

Before moving into the specifics of mental health services and instruction, a few words are in order about some fundamental legal and ethical considerations.

Consent and Due Process

There was a time not so long ago when assessing students with problems and assigning them to special programs was done matter-of-factly. Most professionals believed they knew who needed help and what help was needed. It was a relatively simple matter to inform those involved that a problem existed and what was to be done. Growing awareness of rights and of the potentially harmful effects of treatment led to safeguards. Currently, consent is not taken for granted.

Parent organizations and child advocates have insisted that parents be involved in any decision that might have a profound effect on the course of a child's life. This fact is reflected in the "procedural safeguards" enacted into federal law. These safeguards are rooted in the legal concept of due process as established in the Fourteenth Amendment to the federal constitution.

Due process protects people's rights; procedural safeguards are meant to help guarantee that everyone is treated fairly. They are meant to ensure that parents are involved in decisions regarding testing and placement of their child. That is, such interventions are not supposed to take place without parental consent. Exhibit 14 highlights some of the safeguards spelled out in law.

What basic information should be communicated and understood? It is important to clarify the purpose of all intervention activity (why the person is there; what the person will be doing), describe risks and benefits, spell out alternatives, assure the individual that participation is not required, and elicit and answer all questions.

To make sure information is understood, it may need to be presented in a variety of ways. Repeated verbal or written communications, translations, media presentations, question-and-answer follow-ups to evaluate how information was understood, feedback obtained from other consumers -- all may be relevant at various times.

The emphasis on information, and the very term *informed consent*, may sometimes lead to greater emphasis on giving information than on ensuring true consent. Consent is a legal concept that has three major aspects: *capacity*, *information*, and *voluntariness*.

All three elements are of equal importance. These elements can be captured by three questions: Does the person have the ability to consent? adequate information to do so knowledgeably? the freedom to decline?

Exhibit 14: Some Due Process Safeguards

1. Parents must be notified whenever the school plans to conduct a special evaluation of their child.

2. Parents have the right to refuse consent for such an evaluation. (However, the school district has the right to a legal hearing to prove it is needed. Should parents want a special evaluation and the school refuses to provide it, parents can seek a legal hearing.)

3. Parents have the right to

   - review the procedures and instruments to be used in any evaluation
   - be informed of the results and review all records
   - obtain an independent educational evaluation to be considered in any decisions.

4. Parents must be notified whenever the school wants to change their child's educational placement, and they have the right to refuse consent for such a change. (Again, the school district can ask for a legal hearing to overrule the parents' decision. And, parents who are unable to convince the school to provide the special placement they want can also seek such a hearing.)

All notifications and explanations are to be given in the parents' primary language or other primary mode of communication.

Where the laws allows, licensed professionals can offer some sensitive services without parent consent. School-based health centers allow for open access once parents have signed an initial consent form that allows the student to use designated services.

In many instances, however, students are not in a position or motivated to follow-through with a referral -- even though their problems may be severe. Thus, more often than not, parent involvement is needed to facilitate follow-through. For example, students may need parents to pay fees and for transportation. If a student is not an emancipate minor, the referral resource will probably require parental consent.

When parent involvement is indicated, the referral intervention includes efforts to help students understand the benefits of such involvement and encourage them to discuss the matter with their parents. School staff can play a major role in facilitating and perhaps mediating a student-parent discussion for students who see the need but are fearful of approaching their parents without support.

> *What if a student is determined not to involve parents?* Except when inaction would place the student or others in extreme danger, some school staff prefer to honor a student's desire to maintain confidentiality. In such instances, the only course of action open is to offer whatever referral follow-up support the school can provide. Some staff, however, believe it is essential for parents to take responsibility for student follow-through. Thus, parents are given referral information, asked to see that the student makes contact, and any needed follow-through support is directed at the parents.

A Note About SBHC Consent Forms

In communicating appropriate information about the center to students and their families, it is essential to use a variety of strategies and often several languages. The information that must be communicated includes:

- why the SBHC has been established
- what services are offered (with special attention to explaining sensitive services such as mental health and birth control)
- who provides the services, where, and during what hours
- how the costs of services are underwritten
- who is eligible to use the center
- how to enroll (with special attention to the informed consent procedure and the right of parents to limit the type of services a student uses)
- confidentiality procedures and limits

Minimally, such information should be in a general flyer/brochure that is circulated to all parents and students and the basic information should also be included in the center's informed consent forms. An example of a SBHC Informed Consent Form is offered as Resource Aid IIIA-1.

Confidentiality and Privacy

Dilemma: *Matt told me in confidence that he is planning a wild weekend with his friends. Given his history of substance abuse and what I know about the friends he mentioned, I'm worried that things will get out of control. Should I warn his parents?*

Student to the Center Staff:

If I tell you something, will you tell my parents?

Confidentiality is an ethical concern. The fundamental intent is to protect a student's/family's right to privacy by ensuring that matters disclosed are not relayed to others without informed consent. By ensuring confidentiality, professionals also hope to encourage communication.

Neither privacy nor confidentiality, however, are absolute rights, especially in the case of minors. There are fundamental exceptions, some involving ethical considerations and some involving legalities.

There are times when professionals would prefer to maintain confidences but cannot do so legally or ethically. Examples include instances when individuals being seen indicates an intention to harm themselves or someone else and when they have been abused. As a result of legislation, litigation, and ethical deliberations, professional guidelines call on interveners to breach the confidence and tell appropriate public authorities when there is a clear danger to the person or to others. Undoubtedly, breaking confidentiality in any case can interfere with the trust between you and a student and make it difficult to help. Prevailing standards, however, stress that this concern is outweighed by your responsibility to prevent various threats.

In this vein, but perhaps going a step further, the ethical guidelines for school counselors call for reporting instances when information provided by clients indicates circumstances likely to have a negative effect on others; that is, without revealing the identity of the client, the counselor is expected to report such circumstances "to the appropriate responsible authority." However, it is left to individual counselors to decide which circumstances are "likely" and what constitutes a "negative effect" that is serious enough to require reporting. One result of all this is to make the processes of ensuring privacy and building trust almost paradoxical.

States vary in the degree to which their laws specify limitations on privileged communication between counseling professionals and minor clients. Some protect only disclosures about problems related to alcohol and other drugs. Others give broad protection, specifying a few exceptions such as reporting child abuse and crime or potential criminal activity. The box on the next page highlights some basics related to understanding the root of confidentiality protections.

In order to adequately inform minors of exceptions to the promise of privacy, you can add a statement, such as

> Although most of what we talk about is private, there are three kinds of problems you might tell me about that we would have to talk about with other people. If I find out that someone has been seriously hurting or abusing you, I would have to tell the authorities about it. If you tell me you have made plan to seriously hurt yourself, I would have to let your parents know. If you tell me you have made a plan to seriously hurt someone else, I would have to warn that person. I would not be able to keep these problems just between you and me because the law says I can't. Do you understand that it's OK to talk about most things here but that these are three things we must talk about with other people?

Because youngsters may feel a bit overwhelmed about the exceptions to privacy and the serious problems described, they may simply nod their acquiescence or indicate that they are unsure about how to respond. To soften the impact, you may want to add statements, such as

> Fortunately, most of what we talk over is private. If you want to talk about any of the three problems that must be shared with others, we'll also talk about the best way for us to talk about the problem with others. I want to be sure I'm doing the best I can to help you.

On Confidentiality

Soler and Peters (1993) stress:

The fundamental right "to be let alone" is at the root of confidentiality protections. Confidentiality restrictions protect the privacy of individuals and insure that personal information is disclosed only when necessary. The reasons for respecting the privacy of children and families include the following:

a. Confidentiality restrictions protect embarrassing personal information from disclosure. This may include histories of emotional instability, marital conflicts, medical problems, physical or sexual abuse, alcoholism, drug use, limited education, or erratic employment.

b. Confidentiality provisions prevent improper dissemination of information about children and families that might increase the likelihood of discrimination or harm against them even if records show that the information is unproven or inaccurate. Such information includes HIV status, mental health history, use of illegal drugs or child abuse charges.

c. Protecting confidential information can be necessary to protect personal security. For instance, an abused woman in a domestic violence situation may be in great danger if law enforcers reveal her new location.

d. Confidentiality provisions also protect family security. For example, many immigrant families shy away from using public health clinics or other social services for that the Immigration and Naturalization Service (INS) will take action against them.

e. Restricting information disclosure may also protect job security. Information such as history of mental health treatment may bear no relation to job performance but could jeopardize the individual's position or ability to find employment.

f. Children and families want to avoid prejudice or differential treatment by people such as teachers, school administrators, and service providers.

g. Confidentiality provisions also may be necessary to encourage individuals to make use of services designed to help them. Adolescents may avoid seeking mental health services at a school-based clinic, for example, if they believe that information will get back to their teachers, parents or peers.

(From *Who should know what? Confidentiality and information sharing in service integration* published by the National Center for Service Integration).

There will be times when you find it in the best interest of a student for others to know something that he or she has disclosed. Most ethical guidelines on confidentiality recognize this. In doing so, guidelines stress that such sharing should occur "only with persons clearly concerned with the case." Given that teachers and parents are clearly connected and see themselves as also working in a student's best interests, some interveners feel it appropriate -- even essential -- to discuss information with them. In other words, there are times when keeping a specific confidence shared by a student works against the youngster's best interests. At such times, you may decide that the costs of not communicating the information to others outweighs the potential benefits of maintaining privacy. Obviously, the first step in such situations is to talk with the student and try to elicit consent for sharing. If you decide you must proceed without consent, you will want to inform the student of why you will be doing so and work to repair any damage to your relationship.

Finally, it should be noted that the sharing of confidential information within and across agencies can be facilitated through developing a *Consent to Exchange Confidential Information*. See Resource Aid IIA-2 for examples of the type of forms being developed around the country to overcome the barriers to the type of sharing that is essential in coordinating services. (Note that the form is designed to meet the varying demands of federal and state laws and education codes.)

Privacy and Confidentiality

There are numerous reasons why it is important to maintain confidentiality in the delivery of health care services to adolescents. Possibly the most important is to encourage adolescents to seek necessary care, but additional reasons include supporting adolescents' growing sense of privacy and autonomy and protecting them from the humiliation and discrimination that could result from disclosure of confidential information.

The confidentiality obligation has numerous sources in law and policy. They include: the federal and state constitutions; federal statues and regulations (such as those which pertain to Medicaid, Title X family planning programs, federal drug and alcohol programs, Title V maternal and child health programs, or community and migrant health centers); state statutes and regulations (such as medical confidentiality statutes, medical records statutes, privilege statutes, professional licensing statutes, or funding statutes); court decisions; and professional ethical standards.

Because these varied provisions sometimes conflict, or are less than clear in their application to minors, it is important that practitioners have some general guidelines to follow -- or questions to ask -- in developing their understanding how to handle confidential information. Confidentiality protections are rarely, if ever, absolute, so it is important for practitioners to understand what *may* be disclosed (based on their discretion and professional judgement), what *must* be disclosed, and what *may not* be disclosed. In reaching this understanding, a few of the most relevant questions include: What information is confidential (since it is confidential information that is protected against disclosure)? What information is not confidential (since such information is not protected)? What exceptions are there in the confidentiality requirements? What information can be released with consent? What other mechanisms allow for discretionary disclosure? What mandates exist for reporting or disclosing confidential information?

In general, even confidential information may be disclosed as long as authorization is obtained from the patient or another appropriate person. Often, when minors have the legal right to consent to their own care, they also have the right to control disclosure of confidential information about that care. This is not always the case, however, since there are a number circumstances in which disclosure over the objection of the minor might be required: for example, if a specific legal provision requires disclosure to parents; a mandatory reporting obligation applies, as in the case of suspected physical or sexual abuse; or the minor poses a severe danger to himself or others.

When the minor does not have the legal right to consent to care, or to control disclosure, the release of confidential information must generally be authorized by the minor's parent or the person (or entity) with legal custody or guardianship. Even when this is necessary, however, it is still advisable -- from an ethical perspective -- for the practitioner to seek the agreement of the minor to disclose confidential information and certainly, at minimum, to advise the minor at the outset of treatment of any limits to confidentiality. Fortunately, in many circumstances, issues of confidentiality and disclosure can be resolved by discussion and information agreement between a physician, the adolescent patient, and the parents without reference to legal requirements.

Excerpted from "The Legal Framework for Minor Consent" by Abigail English written as the introduction to *State Minor Consent Statutes: A Summary* (April, 1995) prepared by the National Center for Youth Law (authored by M. Mathews, K. Extavour, C. Palamountain, & J. Yang).

RESOURCE AIDS

A. Resource Aid Included Here

Resource Aid IIA-1

SBHC Informed Consent Form

An example of the type of consent form SBHC's have found effective.

Resource Aid IIA-2

Consent to Exchange Confidential Information

An example of a form used to overcome barriers to the sharing of confidential information across agencies when it is appropriate to do so (e.g., to coordinate services).

B. Related Resource Aid Packet Available from Our Center

Confidentiality and Informed Consent

Focuses on issues related to confidentiality and consent of minors in human services and interagency collaborations. Also includes sample consent forms.

For Those Interested in Enrolling in the School-Based Health Center

at ______________________ **School**

WHO can use the Center?	*All students* enrolled at the school
HOW can a student use the Center?	Once a student has given us this CONSENT FORM signed by parent/ guardian, the student can walk in and make an appointment or the parent/guardian or a school staff member can ask that the student be seen.
WHY should students use the Center?	Some students can't afford to go to a doctor or counselor. Others have difficulty getting to a doctor or counselor. Students may feel more at ease using a school's Center.
WHEN is the Center open?	*During school hours and at designated other times* (call for specific times)
WHO staffs the Center?	*A team of part time and full time professionals including:* Physician Practitioner Psychologist Nurse Medical Assistant Health Educator
WHAT fees are charged for Center services?	*Services are provided at no cost to students or parents.* That is, no direct fees will be charged to you. Insurance companies or Medical Assistance will be billed when possible and agreeable to you.

(cont.)

WHAT services are provided?

We help students

- *deal with barriers to learning*
- *adopt healthy behaviors*
- *use health services in a wise way*
- *get help early when they have problems*
- *talk to their parents about health and personal concerns*

We offer three plans from which to choose.

Plan 1 = Provides both **GENERAL** and **SPECIAL** Health Services.

Plan 2 = Provides all Health Services except those parents designate below as services the student may not access (cross out any services you do not give consent for the student to use).

Plan 3 = No services may be provided the student at the Center.

General services include:

Physical Care

- Flu and colds
- Infections
- Headaches, earaches
- Sore throats
- Sprains, cuts, burns
- Skin problems
- Abdominal pain, back pain
- Chronic illness
- Physical disability

Personal Counseling

- Self-esteem
- Family counseling
- Relationship counseling
- Sexual abstinence counseling
- Stress and anxiety
- Depression
- Abuse and neglect
- Suicide prevention counseling

Health and Wellness Education

- Physical exams for sports or jobs
- Health screening for blood pressure and cancer
- Immunizations
- AIDS prevention
- Smoking prevention
- Safety promotion

Nutritional Services

- Sports nutrition
- Weight management
- Special Diets

Laboratory Services

- Pap smear
- Urine tests
- Sickle Cell tests
- Diabetes tests
- Routine blood tests
- Throat cultures

***Special* Services** that are available:

Alcohol and drug abuse assessment
Sexually transmitted diseases -- education, diagnosis, treatment
Pregnancy services -- tests, prenatal case management, WIC, option counseling referral
Contraceptive counseling and prescriptions

THE CENTER
DOES NOT PROVIDE abortion counseling or services or contraceptive supplies.

ANY QUESTIONS?

Please feel free to call to ask questions or arrange a visit.
Phone: ______________

The following agreement must be signed before a student can use the Center.

We offer three plans from which to choose.

Plan 1 = Provides both **GENERAL** and **SPECIAL** Health Services.

Plan 2 = Provides only those Health Services which parents designate on the Consent Form as services the student may access.

Plan 3 = Parent wants n*o services* for the student at the Center.

PARENT CONSENT

Please choose **ONLY ONE PLAN. Sign and return form to the school's Health Center.**

Check one of the following. My choice is

_____ *PLAN 1* -- **ALL** GENERAL Medical **AND** SPECIAL Health Services.

_____ *PLAN 2* -- **ALL** Health Center Services **EXCEPT** for those I have crossed out on the preceding page.

_____ *PLAN 3* -- **NO** GENERAL **OR** SPECIAL Health Services.

I have read and understand the services and different PLANS offered by the School's Health Center. I give my permission for ________________________________ to use the plan checked above.
(Student's Name)

Parent/Guardian Signature	Date	Daytime Phone

STUDENT ASSENT

Student's Signature	Date	Daytime Phone

BEST COPY AVAILABLE

CHILDREN'S INTERAGENCY

CONSENT TO EXCHANGE CONFIDENTIAL INFORMATION

PLEASE TYPE/PRINT ALL INFORMATION

Child's Name ______________________________ Birth Date ____________________

Mother's Maiden Name_______________ Father's Name_______________________

Social Security No__________________ Record No. _________________________

I authorize____

to exchange information with

____

Agency/Person/Organization

____

Address

about information obtained during the course of my/my child's treatment/case/service plan for

____.

The exchange of records authorized here is required for the following purpose:

____.

Restriction: Release or transfer of the specified information to any person or agency not named herein prohibited unless indicated below:

Such exchange shall be limited to the following specific types of information: _____________

____

____.

This consent is subject to revocation by the undersigned at any time. It shall terminate, without express revocation on:

____

Date, Event, or Condition

I understand I am entitled to receive a copy of this consent.______ copy(ies) requested and received. I have read this consent carefully and have had all my questions answered.

Date____________________ Witness __________________________________

Signed_________________________ Signed ______________________________

Parent, Guardian, Conservator Case Manager/County Representative

Agency ____________________________

Confidential Client Information

SEE CALIFORNIA WELFARE AND INSTITUTIONS CODE SECTION 5328 AND SECTION 10850. CIVIL CODE 34, 58 AND 1798. 42 C.F.R. SECTION 2.34 AND 2.35. EDUCATION CODE 49075. HEALTH AND SAFETY CODE 1795

RELEASED RECORDS

The following records and/or information was released to:

____

____ Summary of Record

____ Diagnosis / Assessment

____ Social History

____ Treatment Plan

____ Financial Information

____ Psychiatric Evaluation

____ Medical Assessment, Lab, Test, etc.

____ History of Drug / Alcohol Abuse

____ Other Evaluation / Assessment (specify)

____

____

____

____ Results of Psychological/ Vocational Testing

____ Other (specify)

____

____

____

____

____

____

____

____

Released by:

SIGNATURE ____

TITLE ______________________________ DATE ____________________

AUTHORIZATION FOR
RELEASE OF CONFIDENTIAL INFORMATION

Citation Examples:
Health and Safety
Code 5
W&I Code 10850 and 5328
Ed. Code 49075
Civil Code 56 and 1796
42 CFR Part 2

Case Name:

Case Record No.:

Date of Birth:

UNIT IIB: PROBLEM IDENTIFICATION, PREREFERRAL INTERVENTION, AND CONSULTATION WITH SCHOOL STAFF

Contents

Page

- Initial Problem Identification IIB-1
- Prereferral Interventions IIB-2
- Staff Consultation IIB-3
  - >Mental Health Consultation in Schools IIB-3
  - >Collaborative Consultation IIB-3
  - >Barriers to Collaboration IIB-6
  - >Toward School-Based Consultation Teams IIB-7
  - > Offering Consultation and Responding to Requests IIB-8
  - >Concluding Comments IIB-8

Resource Aids IIB-10

A Few Related References IIB-26

BEST COPY AVAILABLE

Exhibits and Resource Aids in Unit IIB

Exhibits

Unit IIB *Page*

15. A Guide for Teachers and Other School Staff Regarding the Prereferral Process IIB-2

16. Building Rapport and Connection IIB-4

Resource Aids

Unit IIB

IIB-1 Helping Students with Psychosocial Problems Seek Help IIB-12

IIB-2 Triage Review Request Form (Request for Assistance in Addressing Concerns About a Student/Family) IIB-13

IIB-3 Being Alert to Indicators of Psychosocial and Mental Health Problems IIB-14

IIB-4 Being Specifically Alert to Substance Abuse Indicators IIB-16

IIB-5 Exploring the Problems with the Student and Family (Guidelines to Give Teachers) IIB-18

IIB-6 Prereferral Interventions: Some Things to Try (Guidelines to Give Teachers) IIB-19

IIB-7 Letter to Teachers Regarding Availability of Consultation IIB-20

IIB-8 Reminder and Survey Related to Identifying Consultation Needs IIB-21

IIB-9 Example of Inservice Presentation to Enhance Staff Skills for Talking and Listening to Students IIB-22

IIB-10 Outline of Key Steps and Tasks in Problem Solving Intervention IIB-25

Unit IIB

Problem Identification, Prereferral Intervention, and Consultation with School Staff

Center staff identify many mental health problems each day. And, of course, some students come seeking help for themselves. Some are best served by helping to ensure that appropriate prereferral interventions are implemented; others can be assisted immediately and directly by center staff; others require referrals.

Initial Problem Identification

Early in a center's development, the emphasis simply is on letting school personnel, students, and parents know that help for psychosocial and mental health concerns is available. This involves educating teachers, peers, parents, and others to ensure they are informed.

To these ends,

- be certain that mental health services and application procedures are described in all center flyers, brochures, and announcements sent to students, school personnel, and parents
- provide an information sheet on *Helping Students with Psychosocial Problems Seek Help* (see Resource Aid IIB-1) to clarify appropriate ways to identify students in need and guide them to help
- make available and readily accessible to all school staff and other potential referral sources a request-for-contact form (see Resource Aid IIB-2).

In keeping with the principle of using the least intervention needed, it is imperative to explore the effectiveness of *prereferral interventions* in assisting identified students before expending resources on screening/assessment and referral. In many instances, prereferral interventions may be a sufficient approach to the problem. At the very least, the assessment data generated by trying such interventions will be useful in making triage and referral decisions.

Over time, you will want to educate potential referrers appropriate indicators of problems (see Resource Aids IIB-3 and 4) and about prereferral interventions and how to help a student decide to seek help and about *all* resources available at school that provide help.

As discussed in other units of the guidebook, if the student is to be assisted at the center, you will want to *assess* the problem for purposes of triage and consulting with the student and concerned others. And if there are accessible referral resources at the school (e.g., a school psychologist, a counselor, a social worker) or in the community, the center will need to be certain there are well developed systems for connecting with such referrals.

Prereferral Interventions

Prereferral interventions require the involvement of classroom teachers and other school staff. Exhibit 15 is a guide center staff might use in helping teachers learn some basic steps to take prior to referring a student for special assistance.

Exhibit 15: A Guide for Teachers and Other School Staff Regarding *the Prereferral Process*

When students have problems, the following steps may be helpful.

Step 1: Based on your work with the student, *formulate a description* of the student's problem (see Resource Aid IIB-2).

Step 2: Have *a discussion* to get the student's view. You may want to include the family (see Resource Aid IIB-5).

Step 3: Try *new strategies* in the classroom based on your discussion (see Resource Aid IIB-6).

Step 4: If the new strategies don't work, *talk to others* at school to learn about additional approaches they have found helpful (e.g., reach out for support/mentoring/coaching, participate with others in clusters and teams, observe how others teach in ways that effectively address differences in student motivation and capability, request additional staff development on working with students who have learning, behavior, and emotional problems).

Step 5: If necessary, use the *school's referral processes* to ask for additional support services.

Step 6: Work with referral resources to *coordinate your efforts* with theirs for classroom success.

Staff Consultation

Essentially, consultation is a collaborative problem solving intervention. Consultants enter into such a collaboration with the intent of improving the nature of intervention activity which others implement (Caplan, 1970; Cole & Siegel, 1990; Conoley & Conoley, 1990; Friend & Cook, 1996; Gutkin & Curtis, 1982; Meyers, Parsons, & Martin, 1979; Rosenfield & Gravois, 1996; Sarason, 1996; Zins, Curtis, Graden, & Ponti, 1988; Zins, Kratochwill, & Elliott, 1994).

Mental Health Consultation in Schools

Mental health consultation focuses on the psychosocial aspects of human behavior and intervention processes and outcomes. In schools, mental health consultation is a critical facet of any comprehensive program to assist staff in addressing student's problems. This need stems from the fact that psychosocial factors must be well understood and accounted for in solving students' learning and behavior problems and reducing dropouts. This is the case in designing direct interventions and when referral for special services is necessary (assuming relevant services are available).

> Although a considerable amount of school mental health consultation is focused on individual student problems, this need not and probably should not be the case. Such collaborative, problem solving consultation can be used to help improve classroom, school, or district-wide programs with respect to both overcoming problems *and* enhancing positive psychosocial development.

Collaborative Consultation

Truly collaborative problem solving requires considerable skill (see Exhibit 16). Even when consultation is sought and those seeking the consultation are highly motivated to problem solve, consultants must be adept at

- initiating and maintaining a working relationship

and

- facilitating collaborative problem solving.

Moreover, consultants must be committed and able to avoid undermining collaboration by sharing their expertise in ways that are consistent with empowering (e.g., equipping) those seeking consultation to solve future problems on their own.

Exhibit 16: Building Rapport and Connection

To be effective in working with another person (student, parent, staff), you need to build a positive relationship around the **tasks** at hand.

Necessary ingredients in building a working relationship are

- minimizing negative prejudgments about those with whom you will be working
- taking time to make connections
- identifying what will be gained from the collaboration in terms of mutually desired outcomes -- to clarify the value of working together
- enhancing expectations that the working relationship will be productive -- important here is establishing credibility with each other
- establishing a structure that provides support and guidance to aid task focus
- periodic reminders of the positive outcomes that have resulted from working together

With specific respect to **building relationships** and **effective communication**, three things you can do are:

- convey empathy and warmth (e.g., the ability to understand and appreciate what the individual is thinking and feeling and to transmit a sense of liking)
- convey genuine regard and respect (e.g., the ability to transmit real interest and to interact in a way that enables the individual to maintain a feeling of integrity and personal control)
- talk with, not at, the individual -- active listening and dialogue (e.g., being a good listener, not being judgmental, not prying, sharing your experiences as appropriate and needed)

Ensuring confidentiality also is fundamental to building a positive working relationship.

Finally, watch out for ego-oriented behavior (yours and theirs) -- it tends to get in the way of accomplishing the task at hand.

With respect to collaborative consultation, Zins and his colleagues (1988) state that it involves

> a nonhierarchical, egalitarian relationship in that both the consultant and the consultee engage in efforts to develop effective intervention techniques. In other words, [they] are considered equal contributors to the problem-solving process as each brings different perspectives and areas of expertise to the situation.
>
> . . . .
>
> Although consultants should not unilaterally solve the problem and tell consultees which strategies to implement, both participants share responsibility for applying their expertise. Neither party should hold back ideas or interact predominantly in a nondirective manner. The purpose of collaboration is to establish an atmosphere that encourages all participants to contribute and share their expertise and resources (Tyler, Pargament, and Gatz, 1983; Zins, 1985) as collaboration can improve the flow of communication (Gutkin and Curtis, 1982) and facilitate creative problem solving (Sandoval, Lambert, and Davis, 1977). In fact, teachers have been found to prefer collaborative consultation to an expert approach; they perceive the collaborative consultant as being more attentive and the process as resulting in the development of more successful and relevant interventions (Wenger, 1979) (pp.29-30).

Recognizing the importance of consultant commitment to empowerment of those seeking consultation, Pugach and Johnson (1989) state that empowerment is

> a tricky issue relative to collaborative consultation. . . . For collaborative working relationships to be realized, specialists will have to work hard to shed the "expert" image to which they have been socialized and which many classroom teachers have come to expect of them. . . . Currently, a realistic balance has not been achieved . . . . What remains to be seen is whether we can challenge ourselves to advance to the next level, that is, recognizing collaboration can occur only when all participants have a common understanding of their strengths and weaknesses and demonstrate a willingness to learn from each other (p. 235).

On consulting in the schools:

We do not know to what extent we can be of help ....
We do not present ourselves as experts who have answers.
We have much to learn about this helping process ...
together we may be able to be of help to children ....
Sarason, Levine, Goldenberg, Cherlin, & Bennett (1960)

162 BEST COPY AVAILABLE

Barriers to Collaboration

Consultation for those who are not motivated to problem solve raises additional concerns (again see Exhibit 15). Such persons will not only be passive participants in the problem solving process, they are unlikely to follow-through on potential solutions. In such cases, the consultant also needs skills related to

- understanding reactive and proactive barriers to problem solving

and

- dealing with barriers to problem solving (especially affective interference).

> As discussed in Unit IB, common barriers arise from differences in sociocultural and economic background and current lifestyle, skin color, sex, power, status, and professional training. In working relationships, differences can be complementary and helpful -- as when staff from different disciplines work with and learn from each other. However, differences become a barrier to establishing effective working relationships when negative attitudes are allowed to prevail. Interpersonally, the result generally is avoidance or conflict and poor communication.

When the problem is *only* one of lack of awareness and poor skills, it is relatively easy to overcome. Most motivated professionals can be directly taught ways to improve understanding and communication and avoid or resolve conflicts that interfere with working relationships. There are, however, no easy solutions to overcoming deeply embedded negative attitudes. Certainly, a first step is to understand that the nature of the problem is not differences per se but negative perceptions stemming from the politics and psychology of the situation.

> It is these perceptions that lead to (1) prejudgments that a person is bad because of an observed difference and (2) the view that there is little to be gained from working with that person. Thus, minimally, overcoming negative attitudes interfering with a particular working relationship involves finding ways (1) to counter negative prejudgments (e.g., to establish the credibility of those who have been prejudged) and (2) to demonstrate there is something of value to be gained from working together.

Proactive steps toward building positive connections involve such fundamentals as conveying genuine empathy, warmth, regard, and respect and avoiding such dynamics as the "expert trap" and "rescue transactions." Self-criticism and self-disclosure can help create an atmosphere where defensiveness is minimized. Also, helpful is the expression of appreciation for efforts in the right direction. After a positive working relationship is established, it becomes feasible for the persons involved to help each other reduce inappropriate prejudgments and become increasingly sensitive to important differences related to status, power, culture, race, sex, age, professional training, and so forth.

Toward School-Based Consultation Teams

Where support in the form of consultation is available and readily accessible, it can be extremely beneficial to school staff and students and their families. Unfortunately, traditional models of mental health consultation designed to send in a mental health professional in response to each special request are too costly for most school districts to provide. Thus, the need for a model that uses and upgrades the talents of existing school staff to provide consultation to their colleagues with respect to student psychosocial problems.

> That is, it is recognized that, at best, most districts can afford only a relatively few highly trained mental health professionals. Rather than exhausting this special resource with direct service (e.g., assessment and counseling) and direct consultation activity, a small cadre of mental health professionals can rotate from school to school helping relevant on-site staff create and evolve school-based psychosocial consultation teams. Once established, the members of such a team would be available and accessible to the rest of the school staff for mental health consultation regarding individual students and particular events. And, as a team, they would work together to identify, coordinate, and develop additional resources for meeting the psychosocial needs of students at the school (e.g., linking and publicizing existing programs, improving referral processes, upgrading crises responses, arranging for mental health inservice education, developing new psychosocial programs).

Teacher Assistance Teams

One prereferral method uses teacher assistance teams (TATs) which also go by such labels as staff support teams, intervention assistance teams, etc. Stokes (1982) defines a TAT as "a school based problem-solving group whose purpose is to provide a vehicle for discussion of issues related to specific needs of teachers or students and to offer consultation and follow-up assistance to staff..." TATs are typically comprised of regular classroom, teachers; however, in some settings, TATs also include representatives from multiple disciplines, such as psychology or special education. TATs focus on intervention planning, usually prior to referral and assessment, rather than on placement. The TAT and the referring teacher meet to discuss problems the student is having, think of possible solutions, and develop a plan of action to be implemented by the referring teacher. Assessment data are gathered by TATs for the purpose of planning and monitoring the effectiveness of interventions. Follow-up meetings are held to discuss the effectiveness of the proposed interventions, and to develop other strategies if necessary. Ultimately, the TAT decides whether the student should be referred to special education (Garcia & Ortiz, 1988).

Rosenfield and Gravois (1996) use the concept of an Instructional Consultation Team as their approach for collaborative problem solving consultation.

Offering Consultation and Responding to Requests

Most school personnel need frequent reminders that mental health consultation is available. To this end, participating schools and personnel can be sent flyers and letters periodically and presentations at school staff meetings can be offered each year (see Resource Aid IIB-7 and 8).

> Typically, mental health consultants are called upon to provide general support for teachers and to help analyze and determine ways to approach students with problems. From the perspective of the least-intervention needed continuum, the consultant's first concern often is to help staff members understand school adjustment problems and how to deal with them in general. When a specific student is of concern, the consultant collaborates in efforts to clarify the nature of the problem and the degree of intervention that seems most appropriate (i.e., least disruptive and intrusive given the student's needs).

Follow-up information from the teacher clarifies when a chosen strategy has proven to be ineffective. In such cases, the focus of consultation shifts to an exploration of a more intensive, specialized intervention.

> In addition to providing assistance and inservice education in the form of direct on-site consultation, a hotline has proven to be a useful way of encouraging and responding with prompt attention to concerns.

Consultants also are asked to provide formal presentations. A common need, for example, is to help staff improve skills for talking with and listening to students (see Resource Aid IIB- 9).

Concluding Comments

Consultation is not an end in itself. The aim of consultation is to solve problems; the reason for consultation is to provide an additional form of assistance for those who carry out direct interventions in hopes that this aim will be achieved (see Resource Aid IIB-10 for an outline of the key steps and tasks in problem solving intervention.).

> The prevailing approach to school mental health consultation involves bringing in specialists with expertise relevant to dealing with a particular problem. It is likely that there will always be instances where such an approach is needed. In the future, however, it seems worth exploring ways to mobilize the variety of individuals in every school who could be useful consultants for the psychosocial concerns that arise at that school.

SBHC staff consultation with school staff usually is thought of as a direct interchange focused on specific problems. And, indeed, initial consultation activity offered by a SBHC staff member usually follows this model. At the same time, as suggested in the introduction, it has been recognized that a model is needed that uses and upgrades the talents of existing school staff to provide consultation to their colleagues with respect to psychosocial concerns. Thus, as discussed in Unit IB, it is essential that SBHC staff think in terms of helping a school develop its own consultation team for dealing with psychosocial concerns.

> Although a primary emphasis of SBHCs is to address the problems manifested by students with specific problems, the problem solving efforts of school-based consultation are seen as enhancing resources for all students at the school. This is accomplished because effective consultation improves a school's response to psychosocial problems by enhancing staff competence and stimulating programmatic changes.

Thus, consultation by SBHC staff is seen as potentially encompassing not only matters related to the causes and correction of individual students' problems, but also advocating for and helping to

- establish a Resource Coordinating Team focused on enhancing systems and addressing problems related to problem identification, prereferral intervention, collaborative consultation, screening, triage, referral, crisis response and prevention, counseling, mental health education, management of care, and concerns about consent, confidentiality, legal reporting requirments, and school district and SBHC policies

- identify programmatic resources available to the school and clarification of the needs of school staff with respect to psychosocially relevant concerns

- plan and implement staff inservice education and student mental health education.

RESOURCE AIDS

A. Resource Aids Included Here

Resource Aid IIB-1

Helping Students with Psychosocial Problems Seek Help

This information sheet and request for contact form can be circulated to all school staff and other potential referral sources to raise consciousness regarding their role and clarify appropriate ways to (a) identify students with psychosocial problems and (b) guide them to help.

Resource Aid IIB-2

Triage Review Request Form

This form is used to request assistance in addressing concerns about a student/family. It encompasses a checklist for identifying the nature and scope of the apparent problem, current school functioning, and whether the student/family has asked for assistance.

Resource Aid IIB-3

Being Alert to Indicators of Psychosocial and Mental Health Problems

This handout is designed to assist in educating staff about appropriate indicators of psychosocial and mental health problems.

Resource Aid IIB-4

Being Specifically Alert to Substance Abuse Indicators

This handout is designed to assist in educating staff about appropriate indicators of substance abuse.

Resource Aid IIB-5

How to Explore Problems with Student/Family (Guidelines to Give Teachers)

This handout is designed to provide teachers with a guide to exploring learning, behavior, and emotional problems with a student and/or family.

Resource Aid IIB-6

Prereferral Interventions: Some Things to Do (Guidelines to Give Teachers)

This handout is designed to provide teachers with a guide to some things to try before referring a student for special help.

Resource Aid IIB-7

Letter to Teachers Regarding Available Consultation

Sample letter inviting teachers to consult with SBHC mental health professional.

Resource Aid IIB-8

Reminder and Survey Related to Identifying Consultation Needs

This form suggests a way to provide school staff with another reminder about the availability of SBHC services and mental health consultation. It also may elicit information about school staff needs.

Resource Aid IIB-9

Example of Inservice Presentation to Enhance Staff Skills for Talking with and Listening to Students

This outline is provided as an example of the type of presentation SBHC staff may help present to school staff.

Resource Aid IIB-10

Outline of Key Steps and Tasks in Problem Solving Intervention

This figure and chart is designed to provide an outline of intervention (including consultation) conceived as problem solving.

B. Related Resource Aid Packet Available from Our Center

Screening/Assessing Students: Indicators and Tools

Designed to provide some resources relevant to screening students experiencing problems. In particular, this packet includes a perspective for understanding the screening process and aids for initial problem identification and screening of several major psychosocial problems.

Resource Aid IIB-1

Information Sheet

HELPING STUDENTS WITH PSYCHOSOCIAL PROBLEMS SEEK HELP

Students with mental health needs are identified by

- self
- center medical staff
- counselors, school nurse, psychologist, or other school personnel
- family
- peers

IF A STUDENT INDICATES S/HE HAS A PROBLEM AND YOU THINK IT SHOULD BE SCREENED BY A MENTAL HEALTH PROFESSIONAL, YOU CAN HELP BY DOING THE FOLLOWING:

Inform and Reassure

Uncertain students often need more information; they also may need reassurance that they won't be coerced into doing something they don't want to do.

(a) Tell the student that the center (e.g., mental health professional) or other school personnel (e.g., counselors, nurse, psychologist) will be glad to explain about available programs that can help.

(b) Stress that no one will try to pressure the student to do anything s/he doesn't want to do. No one will try to make her or him participate in any mental health service. The decision is always the students.

Guide Students to Help

(a) If the student doesn't have parental consent to use the center, explain how s/he should go about getting consent. (Consent forms are available at the health center office.)

OR

If the student doesn't want to go to the center or says s/he can't get consent to do so, explain that other school personnel (such as counselors, the school nurse or psychologist) can provide information about services.

(b) Explain to the student how to go about initiating contact (with the center or other school personnel) for a screening interview. Provide as much support and direction as the student appears to need to initiate this contact (including making certain they know the way to the right office, hours of service, arranging for a summons or a pass, and so forth).

(c) If feasible, follow-up with the student to see whether a contact was made. If contact was not made, try to determine whether additional support and direction is needed to help the student make the contact. (For some students, you might ask if they would like you to make the initial contact and have an appointment arranged for them.)

IF THE STUDENT IS NOT READY TO SELF-INITIATE CONTACT AND YOU FEEL S/HE SHOULD BE INTERVIEWED ANYWAY, INFORM THE MENTAL HEALTH PROFESSIONAL AT THE SBHC.

Resource Aid IIB-2

Triage Review Request Form

(Request for Assistance in Addressing Concerns about a Student/Family)

Extensive assessment is not necessary in initially identifying a student about whom you are concerned. Use this form if a student is having a *significant* learning problem, a *major* behavior problem, or seems *extremely* disturbed or disabled.

Student's Name ____ Date: _______

To: ____________________________________ Title: ____________________

From: ____________________________________ Title: ____________________

Apparent problem (check all that apply):

___ physical health problem (specify) ________________________________

___ difficulty in making a transition
  ( ) newcomer having trouble with school adjustment ( ) trouble adjusting to new program

___ social problems
  ( ) aggressive ( ) shy ( ) overactive ( ) other __________________

___ achievement problems
  ( ) poor grades ( ) poor skills ( ) low motivation ( ) other ______________________

___ major psychosocial or mental health concern

( ) drug/alcoh. abuse
( ) depression/suicide
( ) grief
( ) dropout prevention
( ) gang involvement
( ) pregnancy prevention/support
( ) eating problems (anorexia, bulim.)
( ) physical/sexual abuse
( ) neglect
( ) reactions to chronic illness
( ) self esteem
( ) relationship problems
( ) anxiety/phobia
( ) disabilities

Other specific concerns

Current school functioning and desire for assistance

Overall academic performance
  ( ) above grade level ( ) at grade level ( ) slightly below grade level ( ) well below grade level

Absent from school
  ( ) less than once/month ( ) once/month ( ) 2-3 times/ month ( ) 4 or more times/month

Has the student/family asked for:
  information about service Y N
  an appointment to initiate help Y N
  someone to contact them to offer help Y N

If you have information about the cause of a problem or other important factors related to the situation, briefly note the specifics here (use the back of the sheet if necessary).

Being Alert to Indicators of Psychosocial and Mental Health Problems*

No one should be overzealous in seeing normal variations in student's development and behavior as problems. At the same time, school professionals don't want to ignore indicators of significant problems. The following are meant only to sensitize responsible professionals. They should not be seen as a check list.

> If a student is of significant concern, a request should be made to an appropriate person on the school staff who can do some further screening/assessment.

If they occur frequently and in a variety of situations and appear rather serious when you compare the behavior with other students the same age, the following behaviors may be symptomatic of significant problems.

Emotional appearance

(Emotions seem excessive. Displays little affect. Very rapid shifts in emotional state.)

very unhappy, sad, teary, depressed, indicates a sense of worthlessness, hopelessness, helplessness

very anxious, shy

very afraid, fearful

can't seem to control emotions

doesn't seem to have feelings

Personal Actions

(Acts in ways that are troublesome or troubling)

very immature

frequent outbursts/temper tantrums, violent

often angry

cruel to animals

sleep problems and/or nightmares

wetting/soiling at school

easily distracted

impulsive

steals

lies often

cheats often

destroys things

accident prone

unusual, strange, or immature speech patterns

often doesn't seem to hear

hurts self, self-abusive

easily becomes overexcited

truancy, school avoidance

trouble learning and performing

eating problems

sets fires

ritualistic behavior

seizures

isolates self from others

complains often about physical aches and pains

unaccounted for weight loss

substance abuse

runs away

Interactions with others

(Doesn't seem interested in others. Can't interact appropriately or effectively with others.)

- doesn't pay attention
- cruel and bullying
- highly manipulative
- alienates others
- has no friends
- refuses to talk
- promiscuous
- excessively reactive and resistant to authority
- highly aggressive to others -- physically, sexually

Indicators of Unusual Thinking

(Has difficulty concentrating. May express very strange thoughts and ideas.)

- worries a lot
- doesn't stay focused on matters
- can't seem to concentrate on much
- preoccupied with death
- seems to hear or see things, delusional

*Additional indicators for problems (such as depression in young people) are available through a variety of resources -- for example, see the organizations listed in the Resource Aid packet on *Where to Get Resource Materials to Address Barriers to Learning* -- available from the Center for Mental Health in Schools at UCLA.

Being Specifically Alert to Substance Abuse Indicators

It is essential to remember that many of the symptoms of substance abuse are common characteristics of young people, especially in adolescence. This means *extreme caution* must be exercised to avoid misidentifying and inappropriately stigmatizing a youngster. *Never* overestimate the significance of a few indicators.

The type of indicators usually identified are

- a *prevailing pattern* of unusual and excessive behaviors and moods
- recent *dramatic* changes in behavior and mood.

School staff and those in the home need to watch for

- poor school performance; skipping or ditching school
- inability to cope well with daily events
- lack of attention to hygiene, grooming, and dress
- long periods alone in bedroom/bathroom apparently doing nothing
- extreme defensiveness; negative attitudes; dissatisfied about most things; argumentative
- frequent conflicts with others; verbally/physically abusive
- withdrawal from long-time friends/family/activities
- disregard for others; extreme egocentricity
- taking up with new friends who may be drug users
- unusual tension or depressed states
- seems frequently confused and "spacey"
- often drowsy
- general unresponsiveness to what's going on (seems "turned off")
- increasing need for money; disappearance of possessions (e.g., perhaps sold to buy drugs); stealing/shoplifting
- excessive efforts to mislead (lying, conning, untrustworthy, insincere)
- stooped appearance and posture
- dull or watery eyes; dilated or pinpoint pupils
- sniffles; runny nose
- overt indicators of substance abuse (e.g., drug equipment, needle marks)

In the period just after an individual has used drugs, one might notice mood and behavioral swings -- first euphoria, perhaps some unusual activity and/or excessive talking, sometimes a tendency to appear serene, after a while there may be a swing toward a depressed state and withdrawal. Sometimes the individual will stare, glassy-like at one thing for a long time.

To be more specific about a few indicators of abuse categorized by some common substances that are abused:

Amphetamines (stimulants)

excessive activity
rapid speech
irritability
appetite loss
anxiety
extreme moods and shifts
erratic eating and sleeping patterns
fatigue
disorientation and confusion
increased blood pressure and body temp.
increased respiration
increased and irregular pulse
tremors

Cocaine (stimulant, anesthetic)

short-lived euphoria followed by depression
nervousness and anxiety
irritability
shallow breathing
fever
tremors
tightening muscles

Inhalants

- euphoria
- intoxicated look
- odors
- nausea
- drowsiness
- stupor
- headaches
- fainting
- poor muscle control
- rapid heartbeat
- anemia
- choking

Cannabinoids (e.g., marijuana, hash, THC)

- increased appetite initially
- decreased appetite with chronic use
- euphoria
- decreased motivation for many activities
- apathy, passivity
- decreased concentration
- altered sense of time and space
- inappropriate laughter
- rapid flow of ideas
- anxiety; panic
- irritability, restlessness
- decreased motor skill coordination
- characteristic odor on breath and clothes
- increased pulse rate
- droopy, bloodshot eyes
- irregular menses

Narcotics (e.g., opium, heroin, morphine, codeine, methadone, and other pain killers)

- extreme mood swings
- poor concentration
- confusion
- insensitivity to pain
- drowsiness/decreased respiration
- slow, sallow breathing
- decreased motor coordination
- itchiness
- watery eyes/pinpoint pupils
- lethargy
- weight loss
- decreased blood pressure
- possible needle marks
- as drug wears off nausea & runny nose

Barbiturates, sedatives, tranquilizers (CNS depressants)

- decreased alertness
- intoxicated look
- drowsy
- decreased motor coordination
- slurred speech
- confused
- extreme mood swings
- erratic eating and sleeping patterns
- dizzy
- cold, clammy skin
- decreased respiration and pulse
- dilated pupils
- depressed mood state
- disinhibition

Hallucinogens (effecting perceptions; e.g., PCP, LSD, mescaline)

- extreme mood alteration and intensification
- altered perceptions of time, space, sights, sounds, colors
- loss of sense of time, place, person
- decreased communication
- panic and anxiety
- paranoia
- extreme, unstable behaviors
- restlessness
- tremors
- nausea
- flashbacks
- increased blood pressure
- impaired speech
- impaired motor coordination
- motor agitation
- decreased response to pain
- watery eyes

(Guidelines to Give to Teachers)

How to Explore the Problem with the Student and Family

As you know the causes of learning, behavior, and emotional problems are hard to analyze. What looks like a learning disability or an attentional problem may be an emotionally-based problem; behavior problems often arise in reaction to learning difficulties; what appears as a school problem may be the result of a problem at home.

> It is particularly hard to know the underlying cause of a problem when the student is unmotivated to learn and perform. It will become clearer as you find ways to enhance the student's motivation to perform in class and talk more openly with you.

The following guide is to help you get a more information about a student's problem.

Make personal contact with student (and those in the home). Try to improve your understanding of why the student is having problems and see if you can build a positive working relationship. Special attention should be paid to understanding and addressing factors that may affect the student's intrinsic motivation to learn and perform.

1. Starting out on a positive note: Ask about what the student likes at school and in the class (if anything).
2. Ask about outside interests and "hobbies."
3. Ask about what the student doesn't like at school and in the class.
4. Explore with the student what it is that makes the things disliked (e.g., Are the assignments seen as too hard? Is the student embarrassed because others will think s/he does not have the ability to do assignments? Do others pick on the student? Are the assignments not seen as interesting?)
5. Explore what other factors the student and those in the home think may be causing the problem?
6. Explore what the student and those in the home think can be done to make things better (including extra support from a volunteer, a peer, etc.).
7. Discuss some new things the student and those in the home would be *willing* to try to make things better.

See student interview form in Unit IIC.

(Guidelines to Give to Teachers)

Prereferral Interventions Some Things to Try

The following list is meant as a stimulus to suggest specific strategies to try before referring a student for special help.

1. Make changes to (a) improve the match between a student's program and his/her interests and capabilities and (b) try to find ways for the student to have a special, positive status in the program, at the school, in the community. Talk and work with other staff in developing ideas along these lines.

2. Add resources for extra support (aide, volunteers, peer tutors) to help student's efforts to learn and perform. This includes having others cover your duties long enough for you to interact and relate with student as an individual.

3. Discuss with student (and those in the home) why the problems are occurring

4. Special exploration with student to find ways to enhance positive motivation

5. Change regular program/materials/environment to provide a better match with student's interests and skills

6. Provide enrichment options in class and as feasible elsewhere

7. Use volunteers/aide/peers to enhance the student's social support network

8. Special discussion with those in the home to elicit enhanced home involvement in solving the problem

9. Hold another special discussion with the student at which other staff (e.g., counselor, principal) join in to explore reasons for the problem and find ways to enhance positive motivation

Resource Aid IIB-7

Sample letter to teachers re. availability of consultation

Dear (Teacher),

We hope you are finding the (school-based health center) helpful. This letter is meant as a brief reminder that mental health consultation also is available to you as another way to explore possible solutions for the problems these students are manifesting.

Some of the ways such consultation might help are to

- work with you to further analyze the problem and what to do about it (including sharing observations and perspectives of the student)
- arranging for a formal case conference
- initiating outreach to parents
- joining you at a parent conference designed to explore the family's role
- initiating referral and supporting follow-through should this become necessary

If you feel some form of collaborative consultation assistance would help, please feel free to contact me at

Sincerely,

Staff Reminder and Survey

REMINDER AND SURVEY TO IDENTIFY CONSULTATION NEEDS

This is just a reminder about the services available through the (school-based health center). We also want to remind you that we are another resource for you when you need to consultant about a student's problems.

Currently, we offer the following services:

(list all services)

1.

2.

3.

4.

5.

We also may be able to help in the following ways if you are interested (check off items to indicate your interest)

( ) 1. Mental health consultation about specific students and their families.

( ) 2. A workshop focused on ways to deal with students (and their families) mental health and psychosocial concerns.

( ) 3. Resource help identifying and obtaining special resources to aid your work with such students.

Are there any other ways you think we might be able to help?

____

____

____

____

(Example of an Inservice Presentation)

IMPROVING SKILLS FOR TALKING WITH AND LISTENING TO STUDENTS

Needs assessment indicated a high priority for techniques and strategies relevant to talking with and listening to students.

A good place to begin is with sharing experiences with each other regarding what works best.

GIVEN:

We all share a common vision of what we'd like to, but may have different ideas about how to get there.

We know a lot. Some of what we know works with some students, some of the time.

WHEN A TECHNIQUE DOESN'T WORK, HOW MIGHT WE UNDERSTAND THE PROBLEM?

Students often

- resent being identified by others as a problem
  (The resentment mobilizes emotions and defensive behaviors e.g., they may become angry/surly, scared/silent; they may deny, try to avoid, make promises they don't intend to keep);
- fear what may happen to information they provide
  (The dilemmas of confidentiality);
- don't want advice and reassurance from "authorities";
  (They have heard most of it before and don't value or trust what they're told);
- perceive all adults as "not like me" and thus think "you can't understand me"
  (They perceive differences in age, sex, language, culture, color).

GENERAL THOUGHTS ABOUT ADDRESSING THE ABOVE MATTERS:

Focus on understanding and changing student perceptions of you and your program.

- *An invitation rather than a summons*
  (Processes that lead students to want and even to seek help on their own);
- *Respect for what students say*
  >validating students concerns and feelings
  >offering real alternatives and choice in problem solving
  >ensuring appropriate confidentiality
- *Building a helping relationship*
  (Recognizing when a socialization agenda is in conflict with helping; use of techniques such as self-disclosure)
- *Building trust*
  (Recognizing that trust evolves and has its limits)
- *Facilitating change*
  (Understanding the match in terms of student motivation and capabilities; creating groups -- the benefits of sharing with others in comparable situations)

SPECIFIC IDEAS:

INITIATING TALK (Building Trust/Mutual Respect/Motivational Readiness)

In general,
- >create a private space
- >avoid interruptions
- >start slowly to minimize sense of pressure
- >encourage student to take the lead
- >listen with interest
- >if needed, guide student with structured interviews, surveys, sentence completion
- >clarify the role and value of keeping things confidential

In addition, for groups,
- >facilitate sharing through various activities (dyads, background)
- >clarify that trust, respect, confidentiality, etc. are a function of commitment to the group -- not a matter of stating rules

KEEPING TALK GOING (Maintaining Trust/Respect/Motivation)

In general,
- >focus on areas of interest, strength, self-esteem, as well as on analyzing problems
- >build on previous contacts by referring to what has been shared
- >continue to follow students leads in analyzing problems and avoid procedures they may perceive as efforts to control them
- >continue to convey that the intent is to help not socialize

In addition, for groups,
- >draw out similarities in experience and problems with a view to encouraging students to see the value of helping each other
- >help students understand that giving advice usually is ineffective

INITIATING CHANGE (Problem Solving)

In general,
- >help student identify a range of alternatives -- at first in a brainstorming way that helps to creatively break set
- >explore pros and cons of alternative solutions in a way that validates student's perceptions
- >help students choose an alternative -- hopefully a realistic and modest short-term objective
- >identify ways that potential barriers will be overcome

In addition, for groups,
- >clarify that some solutions are better for one person than another
- >identify how students can support each other in reaching objectives

GROUP DISCUSSION AND SHARING:

Focus -- ideas that work and where you feel stuck

Process --

(1) Divide into 4 small groups based on the age of the students with whom you work (i.e., 1 hi school, 1 jr. high, and 2 elementary groups).
(2) Start with each group member relating strategies that have worked.
(3) After each has shared, move on to have each relate an experience when s/he has been frustrated by being unable to engage a student in dialogue. Choose one of these examples to discuss.
(4) Create a role-playing situation -- with the person who shared the problem acting as the student and another group member volunteering to be the outreach consultant. (As the situation evolves, others may want to enter in.)
(5) Have a debriefing discussion to see which techniques seem to help and what doesn't work well.

CLOSING:

Feeling you can really talk *with* students can help make your job feel less overwhelming and more satisfying.

> "To help others you have to know what they need, and the only way to find out what they need is for them to tell you. And they won't tell you unless they think you will listen ... carefully. And the way to convince them you will listen carefully is to listen ... carefully."
>
> David Nyberg
> *Tough and Tender Learning*

A Few Reference

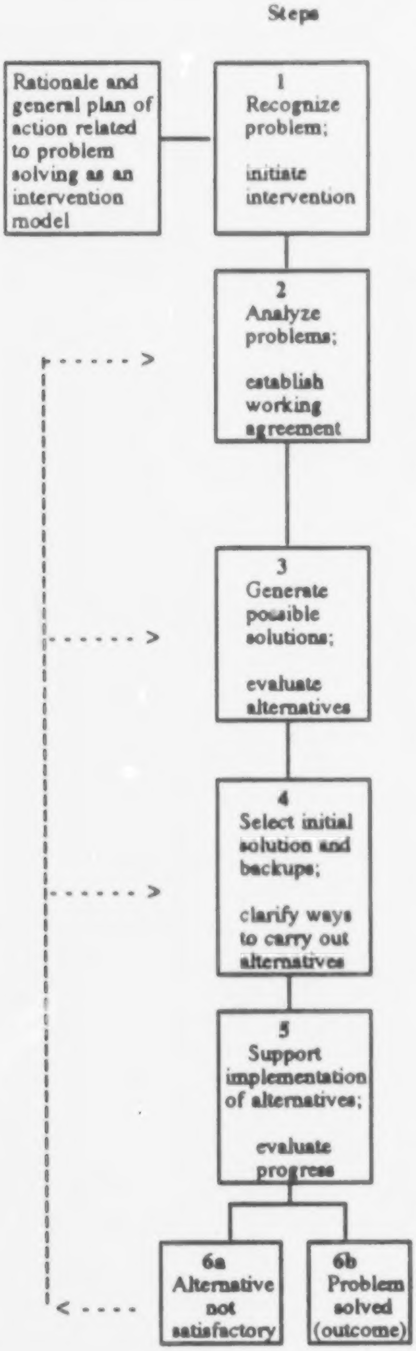
How to Talk So Kids Will Listen and Listen So Kids Will Talk
by A. Faber & E. Mazlish

Teacher and Child
by Haim Ginot

Systematic Training for Effective Parenting
by D. Dinkmeyer & G. McKay

Systematic Training for Effective Parenting of Teens
by D. Dinkmeyer & G. McKay

Outline of Key Steps and Tasks in Problem Solving Intervention


Rationale and general plan of action related to problem solving as an intervention model

Steps	Tasks
1 Recognize problem; initiate intervention	(a) Be aware of the problem (b) Decide intervention is needed (c) Initiate intervention tentatively (d) Build relationship (e.g., trust/respect) (e) Deal with emotional charge (e.g., fears, anger) (f) Become aware of mutual expectations related to intervention
2 Analyze problems; establish working agreement	(a) Mutually assess the problem (b) Come to a shared understanding of the problems, including diagnostic classification if needed and cause-effect (functional) analyses if feasible (c) Work through to shared understanding of expectations for working together (d) Develop attitudes toward effective problem solving (e.g., openness to innovative solutions, deferring judgments)
3 Generate possible solutions; evaluate alternatives	(a) Come to a shared understanding of alternatives for solving the problem, deferring judgment as much as is reasonable (b) Use new information arising from process to further clarify the problem (c) Develop criteria for evaluating pros and cons of alternatives (d) Apply criteria
4 Select initial solution and backups; clarify ways to carry out alternatives	(a) Come to a shared understanding of proposed solution (e.g., implications and subtleties) (b) Evaluate additional alternatives that arise (c) Choose primary and backup solutions (d) Develop plan for achieving selected alternatives (e.g., identify support/skill needs) (e) Develop needed skills (f) Develop criteria for deciding whether problem is resolved or whether to adopt backup
5 Support implementation of alternatives; evaluate progress	(a) Deal with emotional charge (b) Continue development of needed skills (c) Make formative evaluation (d) Apply criteria to decide whether to shift to backup solution
6a Alternative not satisfactory 6b Problem solved (outcome)	(a) Make formative and summative evaluations (outcomes provide data for decisions) (b) Apply criteria regarding need for other alternatives (c) If alternative has not been satisfactory, analyze feedback to determine whether information suggests additional alternatives (e.g., alternatives not previously realized or perspectives of the problem that were not previously understood and that may lead to new alternatives)

BEST COPY AVAILABLE

A Few Related References

Adelman, H.S., & Taylor, L. (1993). *Learning problems and learning disabilities: Moving forward.* Pacific Grove, CA: Brooks/Coles.

Caplan, G. (1970). *The theory and practice of mental health consultation.* New York: Basic Books.

Cole, E., & Siegel, J.A. (Eds.). (1990). *Effective consultation in school psychology.* Lewiston, NY: C.J. Hogrete.

Conoley, J.C., & Conoley, C.W. (1990). *School consultation: Practice and training* (2nd ed.). New York: Pergamon Press.

Friend, M., & Cook, L. (1996). *Collaboration skills for school professionals* (2nd ed.). National Professional Resources, Inc.

Garcia, S.B., & Ortiz, A.A. (1988). *Preventing inappropriate referrals of language minority students to special education.* Occasional Papers in Bilingual Education. NCBE New Focus #5. Silver Spring, MD: National Clearinghouse for Bilingual Education (EDRS # ED309591).

Gutkin, T.B., & Curtis, M.J. (1982). School-based consultation: Theory and techniques. In C.R. Reynolds & T.B. Gutkin (Eds.), *The handbook of school psychology.* New York: Wiley.

Meyers, J., Parsons, R.D., & Martin, R. (1979). *Mental health consultation in the schools: A comprehensive guide for psychologists, social workers, psychiatrists, counselors, educators, and other human service professionals.* San Francisco: Jossey-Bass.

Pugach, M.C., & Johnson, L.J. (1989). The challenge of implementing collaboration between general and special education. *Exceptional Children, 56,* 232-235.

Rosenthal, S.A. & Gravois, T.A. (1996). *Instructional consultation teams: Collaborating for change.* New York: Guilford.

Sandoval, J., Lambert, N.M., & Davis, J.M. (1977). Consultation from the consultee's perspective. *Journal of School Psychology, 15,* 334-342.

Sarason, S.B., Levine, M., Goldenberg, I.I., Cherlin, D.L., & Bennett, E.M. (1960). *Psychology in community settings: Clinical, educational, vocational, social aspects.* New York: Wiley & Co.

Sarason, S.B. (1996). *Revisiting "The culture of school and the problem of change."* New York: Teachers College Press.

Stokes, S. (1982). *School-based staff support teams: A blueprint for action.* Reston, VA: Council for Exceptional Children.

Tyler, F.B., Pargament, K.I. and Gatz, M. (1983). The resource collaborator role: A model for interactions involving psychologists. *American Psychologist, 38*, 388-398.

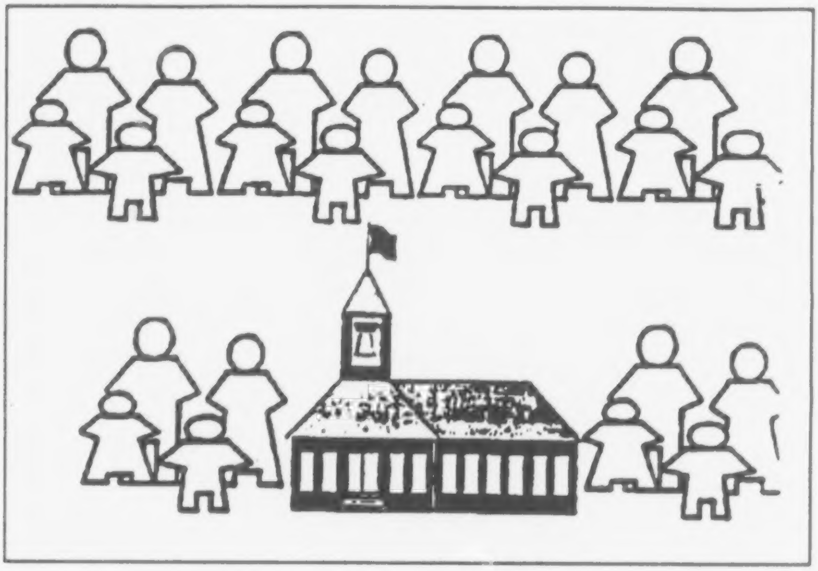
Wenger, R.D. (1979). Teacher responses to collaborative consultation. *Psychology in the Schools, 16*, 127-131.

Zins, J.E. (1985). Work relations management. In C.A. Maher (Ed.), *Professional self-management.* Baltimore: Brooks.

Zins, J.E., Curtis, M.J., Graden, J.L., & Ponti, C.R. (1988). *Helping students succeed in the regular classroom: A guide for developing intervention assistance programs.* San Francisco: Jossey-Bass.

Zins, J.E., Kratochwill, T.R., & Elliott, S.N. (1993). Current status of the field. In J.E. Zins, T.R. Kratochwill, & S.N. Elliott (Eds.), *Handbook of consultation services for children* (pp. 1-12). San Francisco: Jossey-Bass.

Module II: *Working with Students Who Come to the Center*



UNIT IIC: SCREENING/ASSESSMENT

Contents *Page*

- More than Identifying a Problem IIC-1
- A Few Procedural Guidelines and Specific Topics to Explore IIC-1

Resource Aids IIC-7

A Few Related References IIC-21

Exhibits and Resource Aids in Unit IIC

Exhibits

Unit IIC *Page*

17. A Basic Interview Format IIC-2

18. Outline of Specific Areas and Topics that Might Be Explored to Better Understand the Nature and Scope of Problems IIC-4

Resource Aids

Unit IIC

IIC-1 Health Center Student Registration Form and Screening Questionnaire IIC-9

IIC-2 Student's View of the Problem -- Initial Interview Form IIC-13

IIC-3 Substance Abuse Checklist IIC-19

Unit IIC
Screening/Assessment

Screening is part of the registration process at most SBHCs (see Resource Aid IIC-1). Screening can be used not only to clarify and validate the nature, extent, and severity of a problem, but also to determine the student's motivation for working on the problem (see Resource Aid IIC-2). If the problem involves significant others, such as family members, the assessment also can help determine the need for and feasibility of parental or family counseling .

If a walk-in screening interview is not feasible, the Center should establish systems that let students make immediate appointments. For example, a confidential sign-in appointment system can be used for those times when staff are not available. From a student's perspective, screening should validate her or his concerns and feelings and lay the foundation for identifying resources for help.

More Than Identifying a Problem

Obviously in a brief session only a limited amount of information can be gather. Choices must be made based upon your understanding of the problem(s) identified and the populations you serve.

In general, you will want to explore

What's *going well?*

What's *not going so well* and
how pervasive and serious are the problems?

What seems to be the *causes* of the problems?

What *already has been tried* to correct the problems?

What *should be done* to make things better?
(What does the student/family think should be done? Do the causes shed any light on what needs to be done? Does what's already been tried shed any light? What are the student/family willing to try? How much do they truly think that things can be made better?)

On the following pages are some aids related to exploring the problem with the student (and family). Included are:

- some procedural guidelines and a basic interview format (see Exhibit 17)
- an outline of specific areas and topics to explore (see Exhibit 18)

Exhibit 17: Some Procedural Guidelines and a Basic Interview Format

Procedural Guidelines

(1) Use a private space.

(2) Start out positive and always convey a sense of respect. (Ask about the good things that may be going on in the student's life, and express an appreciation for these.)

(3) Start slowly, use plain language, and invite, don't demand or be too directive and controlling. In this regard, the initial emphasis is more on conversation and less on questioning.

(4) Indicate clear guidelines about confidentiality (Is it safe for the individual to say what's on his/her mind?)

(5) Convey that you care (empathy, warmth, nurturance, acceptance, validation of feelings, genuine regard).

(6) Be genuine in your demeanor and conversation.

(7) With students who are reluctant to talk, start with relatively nonverbal activity, such as drawing and then making up a story or responding to survey questions that involve choosing from two or more read responses. With younger students, you can also try some "projective questions," such as "If you had three wishes...", "If you could be any animal...", "If you could be any age ...", "If you were to go on a trip, who would you want to go with you?" and so forth. There are also published games designed to elicit relevant concerns from children.

(8) In exploring concerns, start with nonsensitive topics.

(9) Listen actively (and with interest) and at first go where the individual is leading you.

(10) To encourage more information, use open-ended questions, such as "What was happening when she got angry at you?" and indirect leading statements, such as "Please tell me more about..." or direct leading statements such as "You said that you were angry at them?" (Minimize use of questions that begin with "Why;" they often sound confrontative or blaming?)

(cont.)

Exhibit 17 (cont.): **Some Procedural Guidelines and a Basic Interview Format**

A Basic Interview Format

Start out on a positive note

- Ask about the good things that may be going on in the student's life (e.g., Anything going on at school that s/he likes? Interests and activities outside of school?)

Slowly transition to concerns

- Ask about any current concerns (e.g., troubles at school? at home? in the neighborhood? with friends? how long have these problems been evident?)
- Explore what the student/family think may be causing the problem(s).
- Explore what the student/family think should be done to make things better.
- Explore what the student/family might be willing to try in order to make things better.

Expand exploration to clarify current status, problems and their causes related to

- home situation and family relationships
- physical health status
- emotional health status
- school functioning, attitudes, and relationships
- activities and relationships away from school

If appropriate and feasible explore sensitive topics

- involvement with gangs and the law
- substance use
- sexuality

Add any favorite items you think are helpful.

Move on to explore

- What's already been tried to correct the problems
- What the student/family think should be done to make things better and are willing to try

Finally

- Clarify whether they truly think that things can be made better.

Exhibit 18. Outline of Specific Areas and Topics that Might be Explored to Better Understand the Nature and Scope of Problems

To explore what's going well and what's not, you will want to ask about current status related to various aspects of a student's daily life. To this end, Henry Berman, MD, proposes an approach to interviewing that he calls HEADS (**H**ome, **E**ducation, **A**ctivities, **D**rugs, and **S**exuality). This acronym is meant to guide the interviewer in exploring key facets of a young person's life, especially those that may be a source of trouble.

Borrowing and adding to this framework, the following areas and topics might be explored with respect to current status. *Where problems are identified, past circumstances related to the area and topic can be further discussed to help clarify duration, possible causes, and past or current efforts to deal with them.*

Home & Health?

Place of residence?

- Where does the student live and with whom?
- Physical conditions and arrangements in the residence?
- Family status, relationships, and problems? (separation, loss, conflict, abuse, lack of supervision and care, neglect, victimization, alienation)

Physical health?

- Developmental problems?
- Somatic complaints?
- accident proneness?
- Indications of physical or sexual abuse?
- Indications of eating problems?
- Recent physical injury/trauma?

Emotional health?

- Anxieties?
- Fears?
- Frustration?
- Anger?
- Frequent and extreme mood swings?
- Self-image? (degree of: perceived sense of competence/efficacy; sense of worth; feelings of personal control over daily events; feelings of dependency on others; gender concern; self-acceptance; defensiveness)
- Isolation or recent loss?
- Hopes and expectations for the future?
- If unhappy, is s/he depressed?
- If depressed, is s/he suicidal?
- Psychic trauma?
- Symptoms of mental illness? (hallucinations, delusions)

(cont.)

Exhibit 18 (cont.). **Outline of Specific Areas and Topics that Might be Explored to Better Understand the Nature and Scope of Problems**

Education?

School functioning?
  School attended, grade, special placement?
  Learning? (level of skills)
  Performance? (daily effort and functioning, grades)
  Motivation? (interests, attendance)

Relationships at school?
  Behavior? (cooperation and responsiveness to demands and limits)
  Special relationships with any school staff? (anyone really liked or hated)
  Plans for future education and vocation?

Activities?

Types of interests? (music, art, sports, religion, culture, gang membership)

Responsibilities? (caring for siblings, chores, job)

Relationships with peers?
  Any close friends?
  Separation/loss?
  Conflict?
  Abuse?
  Neglect?
  Victimization?
  Alienation?

Relationships with other adults?

Involvement with the law?

How individual usually spends time?

Drugs?

Substance use? abuse? (see Rersource Aid IIC-3)

Sexuality?

Active sexually? (informed about pregnancy and STD prevention?)

Considering becoming active sexually?

Is, has been, or currently wants to be pregnant?

You will also want to use the contact to **observe** aspects of the student/family that can shed additional light on these matters. These include

Appearance: dress, grooming, unusual physical characteristics

Behavior: activity level, mannerisms, eye contact, manner of relating to parent/therapist, motor behavior, aggression, impulsivity

Expressive Speech: fluency, pressure, impediment, volume

Thought Content: fears, worries preoccupations, obsessions, delusions, hallucinations

Thought Process: attention, concentration, distractibility, magical thinking, coherency of associations, flight of ideas, rumination, defenses (e.g., planning)

Cognition: orientation, vocabulary, abstraction, intelligence

Mood/Affect: depression, agitation, anxiety, hostility absent or unvarying; irritability

Suicidality/Homicidality: thoughts, behavior, stated intent, risks to self or others

Attitude/Insight/Strengths: adaptive capacity, strengths and assets, cooperation, insight, judgement, motivation for treatment

In assessing possibilities and motivation for addressing problems, you will want to explore

- desirable and desired, long-terms outcomes
- barriers that may interfere with reaching such outcomes
- immediate needs and objectives for intervention.

And you will want to clarify the student's, parents', and school's role in the process, and any other assistance that is needed, feasible, and desired.

Remember, if you are going to do a formal interview with a student about psychosocial/mental health concerns, you usually need a signed informed consent form from a parent or legal guardian. And, even if it is not required, it is good practice to get the student's assent as well.

RESOURCE AIDS

A. Resource Aids Included Here

Resource Aid IIC-1

Health Center Student Registration Form and Initial Questionnaire

When a student comes to a SBHC for the first time, the matter of informed consent arises (see Unit IIA). Given there is informed consent, a registration form and screening questionnaire are usually filled out.

From a clinical perspective, such forms and questionnaires may be best filled out with the student over a session or two to avoid overwhelming and perhaps scaring the student to the point they will not return. This is especially important for those students who have come seeking specific help.

The forms illustrated here are slightly modified versions shared with us by various school-based health centers. Note that Centers are being encouraged to use standard, computer-linked student registration and encounter forms. The ( ) next to various items are for computer codes; they are left blank here to avoid confusion.

Resource Aid IIC-2

Initial Counseling Interview Form

An example of an interview designed to clarify student view of the problem and her/his need and motivation for help. Two versions are provided: one for use with all but very young students; the other is for use with very young students. In some instances, students are asked to respond prior to meeting with the intervener; in other instances, the interviewer uses the form as a guide while talking with the student.

Resource Aid IIC-3

Substance Abuse Checklist

A initial screening instrument to help focus on possible substance abuse.

B. Related Resource Aid Packets Available from Our Center

Screening/Assessing Students: Indicators and Tools

Designed to provide some resources relevant to screening students experiencing problems. In particular, this packet includes a perspective for understanding the screening process and aids for initial problem identification and screening of several major psychosocial problems.

Assessing to Address Barriers to Learning

Discusses basic principles, concepts, issues, and concerns related to assessment of various barriers to student learning. It also includes resource aids on procedures and instruments to measure psychosocial, as well as environmental barriers to learning.

Resource Aid IIC-1

(Health Center Student Registration Form and Screening Questionnaire)

SCHOOL-BASED HEALTH CENTER

Registration Information Form

___ New ___ Revised

Student's Center ID# ___________ Registration Date: ___/___/___ Consent Form: All Services ___

Designated Services ___

YOUR NAME: ____ SEX: ___ (M/F)

(Please print) Last First Middle

BIRTHDATE: ___/___/___ Grade: ______

RACE: ( )White__ ( )Black__ ( )Latino/Hispanic__ ( ) Asian__ ( )Other______________

ADDRESS: ____

Street Apt. # State Zip Code

HOME PHONE: ____ / ______________

Where were you born? (check one answer)

( )USA_____ ( )Mexico_____ ( )Guatemala____ ( )China_____ ( )Korea____

( )Vietnam_____ ( )Philippines_____ ( )El Salvador____ ( )Other ______________

If born out of the USA, when did you come to this country? Month/Year: _____/_____

PARENT(S) OR LEGAL GUARDIAN(S) NAME(S)

Mother ______________________ Father ______________________

Last First Last First

Other ______________________ RELATIONSHIP: ______________

Last First

Mother's Maiden Name ______________________

(____)______________________ (____)______________________

Work Phone Home Phone

Whose idea is it for you to come to this center? (Check one answer)

( )My own idea ____ ( )School Nurse ____ ( )Center Staff ____ ( )Parent/Guardian ____

( )Friend/School Mate _____ ( )Teacher ____ ( )Other School Staff ______________

( )Other Family Member ______________ ( )Someone else ________________

What is your usual/regular source of medical care? (Check only one)

( )Private Doctor/Clinic ___ ( )Emergency Room___ ( )None ___ ( )Community Clinic___

( )Health Department____ ( )HMO ____ ( )Military Clinic ____ ( )Other ____________

Last Physical Exam: ___/___ Mo./Yr. **Doctor/Clinic Last Seen:** ___/___ Mo./Yr **Last Dental Exam:** ___/___ Mo./Yr.

Page 1

ABOUT YOUR PARENTS

Primary Language (indicate F for father and M for mother)

( )English ___ ( )Spanish ___ ( )Cantonese___ ( )Korean___ ( )Vietnamese___

Other _________

Marital Status: _____ (N= Never married, M = Married, D = Divorced/separated)

Where were your parent's born? (indicate F for father and M for mother)

( )USA_____ ( )Mexico_____ ( )Guatemala____ ( )China_____ ( )Korea____

( )Vietnam_____ ( )Philippines_____ ( )El Salvador____ ( )Other _______________

If born out of the USA, when did they come to this country?

Father: Month/Year: ______/______ Mother: Month/Year: ______/______

Does your family get food stamps? ( )Yes____ ( )No ____ ( )Don't know ____

Are you in the special breakfast/lunch program? ( )Yes____ ( )No ____ ( )Don't know ____

INSURANCE STATUS: (CIRCLE ONE)

NONE HMO PRIVATE MEDI-CAID

BILLABLE _____ Y ____ N

Insurance Company ______________________________ Policy # ______________________

Subscriber # ____

Is student covered by Medi-Caid? Yes _____ No ______ Medi-Caid No. _______________

Name of Insured: ____

Address: ____

Street City State Zip Code

Phone: ____

Parent SS No. ______ - ______ - ______ Student SS No. _______- ______ - ______

Registration Questionnaire

The following questions will help us in serving you. Your responses will be treated confidentially -- except if you indicate that you ***plan*** to hurt yourself or hurt others or if you have been abused.

Your Name: ____________________ Today's Date: ____________ Your Birthdate: _________

Place of Birth : ___________________________

	Yes	**No**	**Not Sure**
1. Are you taking any medications?	___	___	___
2. Do you have any problems that are bothering you these days?	___	___	___
3. Do you have a hard time concentrating in school?	___	___	___
4. Do some teachers pick on you?	___	___	___
5. Are you doing worse than before in school?	___	___	___
6. Are you absent or tardy a lot?	___	___	___
7. Do you think you might not graduate?	___	___	___
8. Do you have relationship problems with friends?	___	___	___
9. Do you feel that you're too sensitive?	___	___	___
10. Do you feel that you're different from other people?	___	___	___
11. Do you get picked on by others?	___	___	___
12. Do you have frequent arguments with your parents?	___	___	___
13. Do people in your family fight, yell at you, or put you down too much?	___	___	___
14. Have you ever been physically punished (hit, slapped, etc.) so that it left bruises or other injuries?	___	___	___
15. Do people in your family expect too much of you?	___	___	___
16. Do you have enough privacy in your home?	___	___	___
17. Do you feel you don't get enough positive attention in your family?	___	___	___
18. Do you feel that people in your family don't understand you?	___	___	___
19. Are you living with someone other than your parents?	___	___	___
20. Does anyone in your family have problems with alcohol/drugs?	___	___	___
21. Has anyone you were close to either died or left you?	___	___	___
22. Do you get angry easily?	___	___	___
23. Do you feel nervous a lot?	___	___	___
24. Do you sleep a lot or have trouble sleeping?	___	___	___
25. Do you get depressed?	___	___	___
26. Do you get headaches, stomach-aches or other pains a lot?	___	___	___

	Yes	No	Not Sur
27. Has anything sexual ever happened that you felt uncomfortable, confused or upset about?			
28. Do you ever seriously think about ending your life?			
29. Have you ever made plans to end your life?			
30. Have you ever tried to end your life?			
31. Would you be interested in learning about programs that serve gay, lesbian, and bisexual youth?			
32. Do you ever get into physical fights?			
33. Have you ever been involved in gang activity?			
34. Have you ever been in trouble with the law?			
35. Have you tried alcohol or other drugs?			
36. Do you use alcohol or other drugs?			
37. Do you ever get drunk or wasted?			
38. Are you having a hard time with the customs of this country?			
39. Have you ever had sex with another person?			
40. Have you had different sexual partners?			

Answer the next questions *only* if you have had sex with another person:

41. Do you worry about "safe sex"/ birth control?			
42. Would you like information about "safe sex"/ birth control?			
43. Have you ever had a sexually transmitted disease?			
44. Have you or your partner been pregnant before?			
45. Do you have any children?			
46. Do you think you or your partner are pregnant now?			
47. Do you or your partner want to get pregnant?			
48. Do you or your partner use birth control?			
49. If yes, which of the following do you use?			
a. birth control pill			
b. foam, jelly, cream, or suppository			
c. a diaphragm			
d. the rhythm method (the right time of the month)			
e. the withdrawal method (pulling out)			
f. other (specify)________________________			

Student's View of the Problem -- Initial Interview Form
(For use with all but very young students)

Interviewer ____________________ Date______________

Note the identified problem:

Is the student seeking help? Yes No

If not, what were the circumstances that brought the student to the interview?

____

Questions for student to answer:

Student's Name ____________________________ Age _____ Birthdate ___________

Sex: M F Grade ________ Current Placement ____________________

Ethnicity __________ Primary Language ____________________

We are concerned about how things are going for you. Our talk today will help us to discuss what's going O.K. and what's not going so well. If you want me to keep what we talk about secret, I will do so -- except for those things that I need to discuss with others in order to help you.

(1) How would you describe your current situation? What problems are you experiencing? What are your main concerns?

(2) How serious are these matters for you at this time?

1 very serious	2 serious	3 Not too serious	4 Not at all serious

(3) How long have these been problems?

___ 0-3 months ___4 months to a year ____more than a year

(cont.)

(4) What do you think originally caused these problems?

(5) Do others (parents, teachers, friends) think there were other causes?
If so, what they say they were?

(6) What other things are currently making it hard to deal with the problems?

(7) What have you already tried in order todeal with the problems?

(8) Why do you think these things didn't work?

(9) What have others advised you to do?

(10) What do you think would help solve the problems?

(11) How much time and effort do you want to put into solving the problems?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	quite a bit	very much

If you answered 1, 2, or 3, why don't you want to put much time and effort into solving problems?

(12) What type of help do you want?

(13) What changes are you hoping for?

(14) How hopeful are you about solving the problems?

1	2	3	4
very hopeful	somewhat	not too	not at all hopeful

If you're not hopeful, why not?

(15) What else should we know so that we can help?

Are there any other matters you want to discuss?

Student's View of the Problem -- Initial Interview Form

(For use with very young students)

Interviewer ____________________ Date ____________

Note the identified problem:

Is the student seeking help? Yes No

If not, what were the circumstances that brought the student to the interview?

____

Questions for student to answer:

Student's Name ____________________________ Age _____ Birthdate ____________

Sex: M F Grade ________ Current Placement ________________________

Ethnicity __________ Primary Language ____________________

We are concerned about how things are going for you. Our talk today will help us to discuss what's going O.K. and what's not going so well. If you want me to keep what we talk about secret, I will do so -- except for those things that I need to discuss with others in order to help you.

(1) Are you having problems at school? ___Yes ___No
If yes, what's wrong?

What seems to be causing these problems?

(2) How much do you like school?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	Quite a bit	Very much

What about school don't you like?

What can we do to make it better for you?

(3) Are you having problems at home? ___Yes ___No
If yes, what's wrong?

What seems to be causing these problems?

(4) How much do you like things at home?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	Quite a bit	Very much

What about things at home don't you like?

What can we do to make it better for you?

(5) Are you having problems with other kids? ___Yes ___No
If yes, what's wrong?

What seems to be causing these problems?

(6) How much do you like being with other kids?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	Quite a bit	Very much

What about other kids don't you like?

What can we do to make it better for you?

(7) What type of help do you want?

(8) How hopeful are you about solving the problems?

1	2	3	4
very hopeful	somewhat	not too	not at all hopeful

If you're not hopeful, why not?

(9) What else should we know so that we can help?

Are there any other things you want to tell me or talk about?

Resource Aid IIC-3

SUBSTANCE ABUSE CHECKLIST*

It is essential to remember that many of the symptoms of substance abuse are common characteristics of young people, especially in adolescence. This means *extreme caution* must be exercised to avoid misidentifying and inappropriately stigmatizing a youngster. *Never* overestimate the significance of a few indicators.

Student's Name ____________________________ Age _____ Birthdate ____________

Date: ________ Interviewer ________________________

(Suggested points to cover with student, parent, other informed sources)

(1) Substance Use

Has the individual used substances in the past?
Y N

In the last year or so? Y N

Does the individual currently use substances? Y N

How often does the individual	Never	Once in a while,	About Once a Week	Several Times a Week	Every Day
drink beer, wine or hard liquor?	1	2	3	4	5
smoke cigarettes?	1	2	3	4	5
smoke marijuana (pot)?	1	2	3	4	5
use a drug by needle?	1	2	3	4	5
use cocaine or crack?	1	2	3	4	5
use heroine?	1	2	3	4	5
take LSD (acid)?.	1	2	3	4	5
use PCP (angel dust)?	1	2	3	4	5
sniff glue (huff)?	1	2	3	4	5
use speed?	1	2	3	4	5
other? (specify)_______________	1	2	3	4	5

Has the individual ever had treatment for a substance problem? Y N

Has anyone observed the individual with drug equipment, needle marks, etc.? Y N

*Use this checklist as an exploratory guide with students about whom you are concerned. Because of the informal nature of this type of assessment, it should not be filed as part of a student's regular school records.

(2) Recent Dramatic Changes in Behavior and Mood

Have there been major changes recently with respect to the individual's

relationship with family members?	Y	N
relationship with friends?	Y	N
performance at school?	Y	N
attendance at school?	Y	N
participation in favorite activities?	Y	N
attitudes about things in general?	Y	N

(3) Prevailing Behavior and Mood Problems

Have any of the following been noted:

poor school performance	Y	N
skipping or ditching school	Y	N
inability to cope well with daily events	Y	N
lack of attention to hygiene, grooming, and dress	Y	N
long periods alone in bedroom/bathroom apparently doing nothing	Y	N
extreme defensiveness; argumentative	Y	N
negative attitudes	Y	N
dissatisfied about most things	Y	N
frequent conflicts with others	Y	N
verbally/physically abusive	Y	N
withdrawal from long-time friends	Y	N
withdrawal from family	Y	N
withdrawal from favorite activities	Y	N
disregard for others; extreme egocentricity	Y	N
taking up with new friends who may be drug users	Y	N
unusual tension or depressed states	Y	N
seems frequently confused and "spacey"	Y	N
often drowsy	Y	N
general unresponsiveness to what's going on (seems "turned off")	Y	N
increasing need for money	Y	N
disappearance of possessions (e.g., perhaps sold to buy drugs)	Y	N
stealing/shoplifting	Y	N
excessive efforts to mislead (lying, conning, untrustworthy, insincere)	Y	N
stooped appearance and posture	Y	N
dull or watery eyes; dilated or pinpoint pupils	Y	N
sniffles; runny nose	Y	N

A Few Related References

Learning Problems and Learning Disabilities: Moving Forward.
H.S. Adelman & L. Taylor. Brooks/Cole Publishing Co.; Pacific Grove, CA:1993.

Assessment.
J. Salvia & J.E. Ysseldyke. Houghton Mifflin Co.; Boston, MA: 1991.

Behavioral assessment.
E.S. Shipiro. In: *Handbook of Behavior Therapy in Education.* J.C. Witt, S.N. Elliot, & F.M.Gresham (Ed.s). Plenum Press: New York, NY: 1988. p. 67-98.

Measuring Up: Standards, Assessment, and School Reform.
R. Rothman. Jossey-Bass, Inc.; San Fransisco, CA: 1995.

Planning and Conducting Needs Assessment: A Practical Guide.
B.R. Witkins & J.W. Altschuld. Sage Publishers, Inc.; Thousand Oaks, CA:1995.

ADHD in the Schools: Assessment and Intervention Strategies.
G.J. DuPaul & G.D. Stoner. Guilford Press; New York, NY: 1994.

Development of a questionnaire for assessing the school environment.
B. Melville, D. Brown, W. Segree, T. Paul, and others (1994-95). *International Quarterly of Community Health Education, 15,* 15-20.

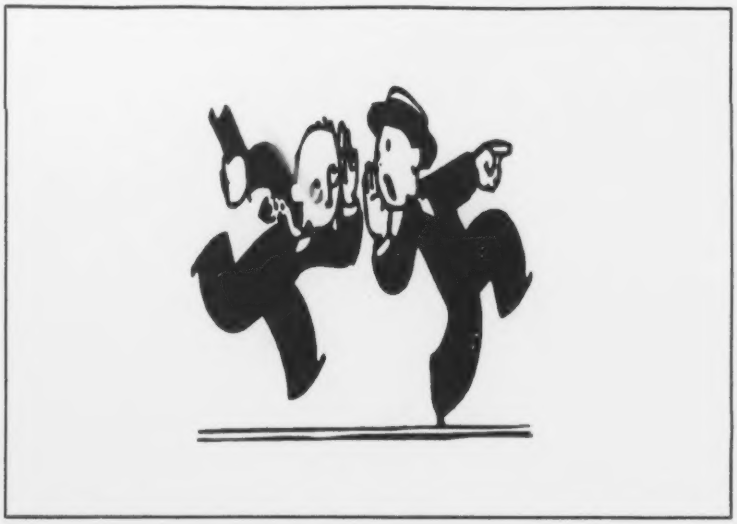
Best Practices in Assessment for School and Clinical Settings.
H.B. Vance (Ed.). Clinical Psychology Publishing Co, Inc.; Brandon, VT: 1993.

Handbook on the Assessment of Learning Disabilities: Theory, Research, & Practice.
H.L. Swanson. Pro-Ed; Austin, TX: 1991

Brief Research Syntheses Available from the ERIC Clearinghouses.

The following are a few more of the many ERIC Digests (research syntheses) related to Assessment. They are available in libraries, over the Internet, or directly from the Educational Resources Information Center (ERIC) by phone, 1-800-LET-ERIC.

- 1995 -- ERIC Digest, number ED388 888 30. New Assessment Methods for School Counselors
- 1995 -- ERIC Digest, number EDO CG 95 3. Mental Health Counseling Assessment: Broadening One's Understanding of the Client and the Client's Presenting Concerns.
- 1995 -- ERIC Digest, number EDO CG 95 11. Emerging Student Assessment Systems for School Reform.



UNIT IID: CLIENT CONSULTATION AND REFERRAL

Contents *Page*

- More than Giving a Name and Address IID-1
- The Referral Process: Some Guidelines and Steps IID-2
- Providing Information about Programs and Services IID-6
- Developing Ways to Facilitate Access to Resources IID-7
  >Highlighting the Most Accessible Referral Resources IID-7
  >Referral Resource Files IID-8
  >Support and Direction for Follow-Through IID-9
  >Personal Contact with Referral Resources IID-10
  >Enhancing On-Campus Services IID-11
- Following-Up on Referrals (including consumer feedback) IID-14

Resource Aids IID-15

Exhibits and Resource Aids in Unit IID

Exhibits

Unit IID *Page*

19. Referral Intervention Guidelines and Steps IID-3

Resource Aids

Unit IID

IID-1 Description of Referral Resource Files IID-17

IID-2 Examples of Resource Information Handouts IID-20

IID-3 Example of One School District's Referral Policy IID-23

IID-4 Referral Decisions -- Summary Form IID-25

IID-5 Guidelines for Acknowledging Status of Referral IID-26

IID-6 Referral Follow-Through Forms and School Record Form of Response to Request for Assistance IID-27

IID-7 Form Used to Aid Follow-Up on Referral Follow-Through IID-30

UNIT IID
Client Consultation and Referral

"They love our clinic and use it often, but they won't cross the street to go to a referral."

Referrals are a central activity of school-based centers.

And, for the most part,

Referrals are relatively easy to make.

BUT,

because most students are reluctant to follow-through on a referral, we usually need to do more than give a student a name and address.

More than Giving a Name and Address

The screening process should lead to (1) identifying appropriate resources for intervention, (2) clarifying procedures for enrollment in a service/program, (3) supporting follow-through.

1. *Identifying Appropriate Resources for Intervention*

A resource file and handouts (see Resource Aids IID-1 and 2) can be developed to aid in identifying appropriate services -- on and off campus -- for specific types of problems (e.g., drug and alcohol programs, suicide prevention, individual or family psychological counseling).

As discussed in Resource Aid IID-1, in identifying appropriate services, first consideration is given to on-campus resources, then to off-campus district services, and finally to services in community agencies. With regard to off-campus referrals, it is important to be aware of school district policies (see Resource Aid IID-3).

At this point, check to be certain the student truly feels the service is a good way to meet her or his needs.

2. *Clarifying Procedures for Enrollment in a Service/Program*

A referral decision form (see Resource Aid IID-4) can provide guidelines in working with students to clarify specific

(a) directions about enrolling in a recommended service and what to do if the service doesn't work out,

(b) problems that might interfere with successful enrollment and how to overcome them (e.g., problems related to parental consent, travel, fees).

A copy of a referral decision form can be given to the student as a reminder of decisions made; the original can be filed for purposes of case monitoring.

Before a student leaves, it is essential to evaluate the likelihood of follow-through on recommendations. Has a sound plan been worked out for doing so? If the matter is in serious doubt, the above tasks bear repeating.

3. Supporting Follow-through

In most cases, it will be necessary to take specific steps to help the student follow-through. For instance, students often need to be put in direct contact (e.g., by phone) with the person who will enroll them in a program.

It is wise to do an immediate check on follow-through (e.g., within 1-2 weeks) to see if the student did connect with the referral. If the student hasn't, the contact can be used to find out what needs to be done next.

The Referral Process: Some Guidelines and Steps

Centers must develop referral *intervention* strategies that effectively

- provide ready reference to information about appropriate referrals
- maximize follow-through by helping students and families make good decisions and plan ways to deal with potential barriers.

A client oriented, user friendly referral intervention is built around recognition of the specific needs of those served and involves clients in every step of the process. That is, the intervention is designed with an appreciation of

- the nature and scope of student problems as perceived by students and their family
- differences among clients in terms of background and resources
- the ethical and motivational importance of client participation and choice.

Moreover, given that many clients are reluctant to ask for or follow-through with a referral, particular attention is paid to ways to overcome factors that produce reluctance.

Exhibit II-19 outlines referral intervention guidelines and steps.

Exhibit II-19. Referral Intervention Guidelines and Steps

Guidelines

A referral intervention should minimally

- provide readily accessible basic information about all relevant sources of help
- help the student/family appreciate the need for and value of referral
- account for problems of access (e.g., cost, location, language and cultural sensitivity)
- aid students/families to review their options and make decisions in their own best interests
- provide sufficient support and direction to enable the student/family to connect with an appropriate referral resource
- follow-up with students (and with those to whom referrals are made) to determine whether referral decisions were appropriate.

These guidelines can be translated into a 9 step intervention designed to facilitate the referral process and maximize follow-through.

(cont.)

Exhibit II-19. (cont.) **Referral Intervention Guidelines and Steps**

*Steps**

Step 1

Provide ways for students and school personnel to learn about sources of help without having to contact you

This entails widespread circulation to students/families and staff of general information about available services on- and off-campus and ways students can readily access services.

Step 2

For those who contact you, establish whether referral is necessary

It is necessary if school policy or lack of resources prevent the student's problem from being handled at school.

Step 3

Identify potential referral options with the client

If the school cannot provide the service, the focus is on reviewing with the student/family the value and nature of referral options. Some form of a referral resource file is indispensable (see Resource Aid IID-1).

Step 4

Analyze options with client and help client choose the most appropriate ones

This mainly involves evaluating the pros and cons of potential options (including location and fees), and if more than one option emerges as promising, rank ordering them.

Step 5

Identify and explore with the client all factors that might be potential barriers to pursuing the most appropriate option

Is there a financial problem? a transportation problem? a parental or peer problem? too much anxiety/fear/apathy?

*Before pursuing such steps, be certain to review school district policies regarding referral (see Resource Aid IID-3).

(cont.)

Exhibit II-19. (cont.) Referral Intervention Guidelines and Steps

Step 6

Work on strategies for overcoming barriers

This often overlooked step is essential if referral is to be viable. It entails taking time to clarify specific ways the student/family can deal with factors likely to interfere with follow-through.

Step 7

*Send clients away with a written summary of what was decided**

That is, summarize

- specific information on the chosen referral,
- planned strategies for overcoming barriers,
- other options identified as back-ups in case the first choice doesn't work out.

Step 8

*Provide client with follow-through status forms**

These are designed to let the school know whether the referral worked out, and if not, whether additional help is needed in connecting with a service.

Step 9

*Follow-up with students/families (and referrers) to determine status and whether referral decisions were appropriate**

This requires establishing a reminder system to initiate a follow-up interview after an appropriate time period.

Obviously, the above steps may require one or more sessions.

If follow-up indicates that the client hasn't followed-through and there remains a need, the referral intervention can be repeated, with particular attention to barriers and strategies for overcoming them. Extreme cases may require extreme measures such as helping a family overcome transportation problems or offering to go with a family to help them connect with a referral.

*See Resource Aids IID-4, 5, 6, and 7 for examples of tools to aid these steps.

Providing Information about Programs and Services

Whether you are in a situation with few or many referral options, it is essential to compile and share basic information about all potential services (see Resource Aids IID-1 and 2). A prerequisite for establishing and updating a good referral information system is to identify a staff member who will accept ongoing responsibility for the system.

> Initially, such activity may take 3-4 hours a week. Maintaining the system probably requires only 1-2 hours per month. The staff member in charge of the system does not need to carry out all the tasks. Much of the activity can be done by a student or community volunteer or an aide.

In gathering information about services, the focus is on clarifying what is offered

- at the school site,
- elsewhere by school district personnel,
- in the local community,
- outside the immediate community.

> If the school does not have a list of on-campus resources, a first step is to survey school staff and prepare a list of on-campus services dealing with psychosocial and mental health concerns (see Resource Aid IID-2).

Similarly, information about other services offered by the school district can be gathered by calling relevant district personnel (e.g., administrators in charge of school psychologists, social workers, health services, special education, counseling).

> In some geographic areas, public agencies (e.g., department of social services, libraries, universities) publish resource guidebooks which list major helplines, crises centers, mental health clinics, drug abuse programs, social service agencies, organizations offering special programs such as weight management, and so forth. Also, in some areas, telephone directories contain special sections on local Human Services.

Developing Ways to Facilitate Access to Service

In carrying out referral interventions to facilitate access to services, it is useful to develop

- materials listing the most accessible referrals and ways to circulate such materials widely,
- a comprehensive referral resource file,
- an array of procedures to support and direct students in following-through on referrals.
- And, it also may be useful to make personal contact with individuals at various agencies and programs as a way of opening doors for students referred from the school.

Highlighting the Most Accessible Referral Resources

Once the most accessible referrals are identified, they can be listed and the lists can be widely circulated (see Resource Aid II-11 for examples). Such listings might take the form of

- 1-2 page handouts,
- wallet-size handouts,
- program description flyers & posters.

To ensure widespread circulation, information on services first can be distributed to all school staff (preferably with a memo from the school administration clarifying the purposes and importance of referring students in need). A follow-up presentation at a school staff meeting is highly desirable.

> For older students, staff can offer to make direct presentations -- at least in classrooms of teachers who play a key role in distributing such information to students (e.g., homeroom or health teachers).

Because of staff changes, new enrollments, and the need for reminders, service information materials might be circulated at least three times during the school year. If the school has a health fair, this provides an excellent opportunity for disseminating service information material along with other relevant pamphlets. Such information also might be published in student newspapers and parent newsletters and as part of periodic health exhibits in school display cases and in health, counseling, and other offices.

Referral Resource Files

A referral resource filing system is intended to contain a comprehensive compilation of basic information on available services (see Resource Aid IID-1).

> Sources for this information are published directories or material gathered directly from programs and agencies. For example, once identified, each service can be asked to provide all relevant program descriptions and information which can be filed alphabetically in separate folders.

Referral files are most useful when the basic information on available services also is categorized. Minimally, categorization should be by location and by the type of problems for which the service can provide help.

> To further facilitate access, the information on each program can be briefly summarized and placed in a binder "Resource Notebook" for easy reference. Minimally, a program summary might itemize
>
> - service fees (if any) and hours
> - whether provision is made for clients who do not speak English
> - specific directions to locations (if off-campus, it is helpful to specify public transportation directions).

Referral resource files should be located where interested students can use them on their own if they so desire. To facilitate unaided use, a set of simple directions should be provided, and files and "Resource Notebooks" need to be clearly labeled.

Support and Direction for Follow-through

Many students are uncertain or not highly motivated to follow-through with a referral; others are motivated to avoid doing so. If we are to move beyond the ritual of providing referrals which students ignore, time and effort must be devoted to procedures that increase the likelihood of follow-through.

This involves finding out:

Does the student agree that a referral is necessary? (See initial interview form in Unit IIC Resource Aid IIC-2.)

> If not, additional time is required to help the student explore the matter. Uncertain students often need more information and should be offered the opportunity to meet with someone (e.g., school counselor, nurse, psychologist) who can explain about available programs. This includes discussing concerns about parental involvement. If such exploration does not result in the student really wanting to pursue a referral, follow-through on her or his own is unlikely. The problem then is whether the student's problem warrants coercive action (e.g., recruiting parents to take the student to the service).

For students who do agree that referral is appropriate but still are not highly motivated to follow-through, intervention focuses on increasing their motivation and providing support as they proceed.

> Student participation in the process of identifying and choosing referral options is seen as one key to increasing motivation for follow-through. Students who feel the choice of where to go is theirs are likely to feel more committed. This is a good reason for working closely with a student at each step in identifying referral options.

Another aspect of enhancing a student's resolve to pursue a referral involves clarifying and addressing any reluctance, concern, and barriers through

- careful exploration of such factors
- specification of strategies to deal with them.

At the conclusion of the referral session(s), a potential enabling device is to provide the student with

- a written summary of referral recommendations and strategies for overcoming barriers
- two follow-up feedback forms -- one for the student to return to the school and one for the referral agency to send back.

See Resource Aids IID-4, 5, 6, and 7 for examples.

Other major supports that might be offered students include

- helping them make initial phone contacts and appointments (including having the student talk directly with the person to be seen)
- providing specific directions and even transportation to the first appointment
- parents or staff accompanying a student to the first appointment
- following-up (as described in a subsequent section).

Personal Contact with Referral Resources

Some staff have found that their referrals receive better attention after they have established a personal relationship with someone in a program or at an agency.

> They accomplish this by periodically phoning and visiting or inviting selected individuals to visit.

In addition to helping establish special relationships that can facilitate access for students referred by the school, these contacts also provide additional information for referral resource files.

When Can Students Seek Assistance without Parent Involvement?

Older students often want or need to access services without their parents knowing and with confidentiality protected. Where the law allows, licensed professionals can offer some sensitive services without parent consent. School-based health centers allow for open access once parents have signed an initial consent form that allows the student to use designated services.

In many instances, however, students are not in a position or motivated to follow-through with a referral -- even though their problems may be severe. Thus, more often than not, parent involvement is needed to facilitate follow-through. For example, students may need parents to pay fees and for transportation. If a student is not an emancipated minor, the referral resource will probably require parental consent.

When parent involvement is indicated, the referral intervention includes efforts to help students understand the benefits of such involvement and encourage them to discuss the matter with their parents. Staff can play a major role in facilitating and perhaps mediating a student-parent discussion for students who see the need but are fearful of approaching their parents without support.

What if a student is determined not to involve parents? Except when inaction would place the student or others in extreme danger, some staff prefer to honor a student's desire to maintain confidentiality. In such instances, the only course of action open is to offer whatever referral follow-through support the school can provide. Some staff, however, believe it essential for parents to take responsibility for student follow-through. Thus, parents are given referral information and asked to see that the student makes contact. Any needed follow-through support is directed at the parents.

Enhancing On-Campus Services

It is given that referral to services offered on-campus ensures accessibility and generally increases follow-through. Therefore, efforts to expand on-campus resources are important to improving follow-through.

Additional on-campus resources can be accomplished by

- recruiting and training interested school personnel and students to offer appropriate services (e.g., mediating, mentoring, counseling)
- outreaching to convince appropriate agencies and professionals to offer certain services on-campus (e.g., arranging for on-campus substance abuse counseling by personnel from county mental health or a local community mental health clinic)
- outreaching to recruit professionals-in-training and professional and lay volunteers
- helping create new programs (e.g., stimulating interest in starting a suicide prevention program and helping train school staff to run it).

CASE EXAMPLE

A 10th grader comes to see you because her home situation has become so distressful she cannot concentrate on her school work, and she is feeling overwhelmed. It's evident she needs support and counseling. Because the school cannot currently provide such services, she has to be referred elsewhere. Thus, it falls to someone at the school to implement a referral intervention. The immediate intervention might be conducted over two sessions, with a follow-up interview done 2 weeks later. The gist of the intervention might take the following form.

Session 1: *Sara, you've been very open in talking with me about the problems you're having at home. It sounds like some regular counseling appointments might help you sort things out.*

Right now, we can`t provide what you need. Because it's important to take care of the problems you've told me about, I want to help you find someone who can offer what you need.

Let's look over what's available. (Referral Resource Files are used -- see Resource Aid IID-1) *We have this information about local counseling resources. The first lists services provided by neighborhood agencies. There are two that might work for you. You said one of the problems is that your father drinks too much. As you can see, one local counseling center is doing a weekly group for Children of Alcoholics who want to talk about their troubles at home. And, on Wednesday afternoons, a social worker from a community center comes to the school to offer individual counseling.*

Not too far away is a counseling program offered by the school district. What might work for you is one of their counseling groups. These are offered on either Tuesday or Thursday after school at a place which is about 3 miles from here.

The program offered here at the school and the one provided by the school district are free; the one at the local counseling center charges a fee of $5 for each session. Both the school district's program and the local counseling center are on the bus line so you could get there on your own.

Why don't you take tonight to think about what might work best for you and maybe make a list of concerns you have that we should talk about. Think about how you feel about meeting with a counselor alone or working with other students in a support group. You may want to talk to your parents before you decide, but you don't have to. However, if you do want counseling, your parents will have to give their consent.

Let's meet again tomorrow to discuss your options and how I can help you make your decision.

(cont. on next page)

CASE EXAMPLE (cont.)

The second session focuses on Sara's (a) anxiety about telling her father she wants to sign up for counseling, (b) concerns about whether to join a group, and (c) preference not to go to an off-campus service. Any other barriers that might hinder follow-through also are worked on.

[After the various pros and cons are discussed and Sara seems to be favoring a particular option . . . .]

> **Session 2:** *So it sounds as if you'd like to see the social worker who comes to campus every Wednesday. We should put that down as your first choice. You also said the Children of Alcoholics group might be worth checking out -- let's put that down as a second choice. . . . And as we agreed, I'll be glad to meet with you and your parents to help you explain that such counseling will be a good thing for you.*
>
> *Let's call your parents now and set up an appointment. . . . Tomorrow, you can call the social worker and make an appointment to talk about signing up for a regular counseling time. . . . If you have trouble with any of this, remember to come back to see me for help.*
>
> II D
>
> *I've written all this down; here's your copy.* (See Resource Aid II-13.) *I'd also like you to let me know how our plans work out. Here's a form for you to return to me; all you have to do is put a check mark to let me know what happened and then drop the form in the school mail box sometime next week.*
>
> *Also, unless you need to come see me before then, I'll be checking with you in two weeks to see how things worked out.*

Follow-up Interview: A "tickler" system (e.g., a notation on a calendar) is set up to provide a daily case monitoring reminder of who is due for a Follow-up Interview (discussed on the next page). The interview explores:

> Has Sara been able to connect with her first or second choices?
>
> If not, why not? And, how can she be helped to do so?
>
> If she has made contact, does it now seem like the right choice was made? If not, the reasons why need to be clarified and additional options explored.

Following-Up on Referrals (including consumer feedback)

Follow-through for most referrals is meant to occur within a two week period. Thus, a good referral system should have a process in place that regularly reviews the status of students who were given referrals three weeks earlier.

The elements of such a system might include

- feedback forms given to clients for themselves and the referral agency (see Resource Aid IID-7)
- a feedback form sent directly to the referral of first choice
- a procedure for daily identification of students due for referral follow-up
- analysis of follow-through status based on feedback
- follow-up interviews with students/families for whom there is no feedback information.

For example:

As part of referral intervention, students/families can be given two types of feedback follow-up forms. In addition, a "back-up" feedback form can be sent directly to the service the student has identified as a first choice.

The client is to return a form to the school to show that contact was made with the referral agency or to clarify why such contact was not made. In either instance, the form reminds the student/family to return for additional referral help if needed.

If contact was made, the student/family might be asked to indicate whether the service seems satisfactory. For anyone who indicates dissatisfaction, the school may want to discuss the matter to determine whether another option should be pursued. If many clients indicate dissatisfaction with a particular agency, it becomes clear that it is not a good resource and should be removed from the referral listings.

The feedback form sent directly to the chosen service simply calls for a confirmation of follow-through. (With on-campus referrals, it has been found useful to establish a reciprocal feedback system.)

If no feedback forms are returned, the student can be invited to explore what happened and whether additional support and direction might help.

RESOURCE AIDS

A. Resource Aids Included Here

Appendix II-A

Connecting a Student With The Right Help

This appendix provides a bit more discussion of processes and problems related to client consultation and referral.

Resource Aid IID-1

Description of Referral Resource Files

Provides a overview of how to establish and maintain referrral resource files and also provides an example of a form used to summarize basic information on agencies and services.

Resource Aid IID-2

Examples of Resource Information Handouts

The types of handouts that can be circulated to students, families, and staff are illustrated. Such full page and wallet-size listings are used to keep everyone aware of readily accessible resources on and off campus.

Resource Aid IID-3

Example of a School District Referral Policy

SBHCs need to be aware of district policy on referrals and release of student information.

Resource Aid IID-4

Referral Decisions -- Summary Form I

This form summarizes (a) specific information on the chosen referral, (b) planned strategies for overcoming barriers, and (c) back-up referral options. At the conclusion of the referral intervention, the student leaves with such a summary and a copy is retained in the student's file.

Resource Aid IID-5

Guidelines for Acknowledging Status of Referral

This information sheet is used to encourage referral resources to report back on student follow-through.

Resource Aid IID-6

Response to Request for Assistance

This form is used to indicate that a request for assistance was attended to and that the referrer was so informed.

Resource Aid IID-7

Referral Follow-Through

The following set of forms are used as aids in facilitating follow-through and for follow-up. One is given to the student at the end of the referral intervention, and the companion form is sent to the referral first choice. Another form is then used to guide and document the follow-through process.

B. Related Resource Aid Packet Available from Our Center

Confidentiality and Informed Consent

Focuses on issues related to confidentiality and consent of minors in human services and interagency collaborations. Also includes sample consent forms.

School-Based Client Consultation, Referral, and Management of Care

Discusses why it is important to approach student clients as consumers and to think in terms of managing *care*, not *cases*. Outlines processes related to problem identification, triage, assessment and client consultation, referral, and management of care. Provides discussion of prereferral intervention and referral as a multifaceted intervention. Clarifies the nature of ongoing management of care and the necessity of establishing mechanisms to enhance systems of care. Examples of tools to aid in all these processes are included.

Description of Referral Resource Files

A comprehensive referral resource filing system is built up in stages. The first stage involves a focus on a few key referrals. Each week, time can be devoted to adding a few more possible services. Once the main services are catalogued, only a little time each week is required to update the system (e.g., adding new services, deleting those that are not proving useful, updating information).

The tasks involved in establishing and maintaining the system can be described as follows:

1. Use available resource systems and directories and contact knowledgeable persons at the school and in the community to identify all possible services.

2. If sufficient information is available from directories and other systems, it can simply be photocopied. In cases where there is insufficient or no information, contact the service (preferably by mail) to request brochures and other materials that describe available services.

3. Use a standard format to summarize basic information for quick review (see attached form). The summary can be done by someone at the center abstracting information that has been gathered about a service or the form itself can be sent to be filled out by someone at the agency and returned.

4. Put the information gathered about each service into a separate folder and label the folder appropriately (e.g., name of agency or program).

5. Sort folders into categories reflecting (a) their location (e.g., on-campus, community-based) and (b) the type of service provided (e.g., counseling/ psychotherapy, substance abuse, vocational guidance, tutoring). File the folders alphabetically, by category in a filing cabinet that can be made accessible to clients

6. Summaries can be exhibited in binder notebooks for quick review. Using separate binder "Resource Notebooks" for each location (e.g., on-campus, community-based), alphabetically insert the summaries into sections labeled for each category of service. There are computerized systems that can be used to store the information for easy access.

7. Files and Resource Notebooks should be put in an area where anyone interested in using them can have ready access. A poster might be hung over the file to call attention to this service information system and how to use it.

8. Listings of the most accessible services can be compiled and widely distributed to all school staff and students.

9. Consumer feedback can be elicited in a variety of ways from student users (e.g., as part of referral follow-through interviews or periodic consumer feedback questionnaires). If clients provide positive feedback on services, their comments can be included in the folders as an encouragement to others. If a number of clients indicate negative experiences with a service, it can be removed from the files.

10. Service listings and filed information and summaries regarding services probably should be updated yearly.

(Referral Resource File)

SUMMARY SHEET ON AN AVAILABLE REFERRAL RESOURCE

The following is basic information provided by an agency and summarized here as a quick overview for anyone interested in the service.

How to contact the service

Name: ________________________ Phone: ____________

Address: _______________________ City ______________

Person to contact for additional information or to enroll in the service:

Name: ________________________ Title: __________

Clients served

Age range: Youngest _____ Oldest ________
Sex: Males _______ Females ________

Type of problems for which services are offered:
(please briefly list)

Ability to serve clients who do not speak English. YES NO
If so, which languages?

If there are any limitations or restrictions related to clients served, please note (e.g., no individuals who are on drugs; only Spanish speaking).

Type of services **Fees:**
(please check services offered)

_____ Assessment _________________
_____ Counseling/psychotherapy _________________
_____ substance abuse treatment _________________
_____ sexual abuse support groups _________________
_____ vocational guidance _________________
_____ tutoring _________________
other (specify)
_____ ________________________ _________________
_____ ________________________ _________________
_____ ________________________ _________________

Sliding Scale? YES NO

If there are any other sources that underwrite fees for the above services, please indicate them (e.g., public agencies, insurance).

SUPPLEMENT TO BROCHURE AND OTHER PRINTED MATERIAL

Along with whatever brochures and printed material that is available, it is helpful to have a summary statement highlighting the following matters.

1. What is the particular philosophical or theoretical orientation underlying the service(s) provided?

2. Please describe the nature of what a client can expect to experience (e.g., time involvement, activities; if groups are involved, indicate typical group size and composition).

3. Specific directions for traveling to the service provider (e.g., using public transportation if off-campus).

4. If there is any other information that should be highlighted for a potential client, please provide it here.

Date this form was filled out: ______________________

Examples of Resource Information Handouts for Students/Families

This and the following pages offer format examples of materials developed to provide students, families, and staff with ready references to key referral resources. It is best if these references are backed up with a Referral Resource File containing summary descriptions and other information on the various services.

ON-CAMPUS MENTAL HEALTH RESOURCES

GENERAL PSYCHOSOCIAL PROBLEMS

Clinic Mental Health Professional -- (name)
information, screening, referral, individual and group therapy, crises, consultation, supervises interns and volunteer professionals offering individual and group psychotherapy

School Nurse -- (name)
information, screening, referral, consultation, supervises interns and volunteer professionals offering individual and group counseling

Clinic Nurse Practitioner -- (name)
information, screening, referral, consultation

School Psychologist -- (name)
information, screening, assessment, referral, individual and group counseling, crises, consultation -- primary focus on special education but available on a limited basis for regular education students

School Counselors
information, screening, and referral

Student Assistance Center -- (name)
information, screening, referral, coordination and facilitation of counseling and self-help groups, training and coordination of peer counselors, consultation

SPECIAL PROBLEM FOCUS

Substance Abuse
Counselor -- (names)
information, screening, referral, treatment, consultation

Psychosocial Problems Resulting from Pregnancy
Counselors from an outside agency who come to the school -- (names)
individual and group counseling, consultation

Teacher for pregnant minors class -- (name)
education, support, consultation

Infant Center -- (name)
education, support, consultation

Dropout Prevention
Advisor -- (name)
individual and group counseling, consultation

RELATED CONCERNS

Clinic Health Educator -- (name)
offers and educational focus in dealing with various problems (e.g., weight problems)

Vocational Educational Advisor -- (name)
job counseling and finding for special education students

(Sample of Flyer Listing Community Resources)

COMMUNITY COUNSELING RESOURCES

The community resources listed below are provided to assist in finding community services. The School District does not assume responsibility for the services provided nor for the fees that may be charged.

Individual, Group, and Family Counseling

Hathaway Childrens Serv.
11600 Eldridge Ave.
Lake View Terr., 91342
(818) 896-1161 Ext. 231

Manos Esperanza
14412 Hamlin
Van Nuys, 91405
(818) 376-0028
(818) 780-9727

North Valley Family
Counseling Center
661 S. Workman St.
San Fernando, 91340
(818) 365-5320

San Fernando Valley
Child Guidance Clinic
9650 Zelzah
(818) 993-9311

Boys & Girls Club
of San Fernando
11251 Glenoaks Blvd
Pacoima, 91331
(818) 896-5261

Because I Love You
General Information Line
(818) 882-4881

El Nido Services
12502 Van Nuys Blv
Pacoima, 91331
(818) 896-7776

Families Anonymous
(818) 989-7841

Sons & Daughters United/
Parents United
Sexually Abused Children (13-18)
Intake: M & T, 1-4:30
(213) 727-4080

Drug Programs

El Proyecto del Barrio
13643 Van Nuys Blvd.
Pacoima, 91331
(818) 896-1135

Vista Recovery Center
7136 Haskell Ave.
Van Nuys, 91406
(818) 376-1600

IADARP - Reseda
(818) 705-4175

Life-Plus
6421 Coldwater Canyon
North Hollywood, 91606
(818) 769-1000

ASAP - Panorama City Hosp.
14850 Roscoe Blvd.
Van Nuys, 91406
(818) 787-2222

Phone Counseling

Valley Hotline
(818) 989-5463

Helpline Youth Counseling
(213) 864-3722

Child Abuse Hotline
Dial 0 -- Ask for
Zenith 2-1234

Suicide Prevention
(213) 381-5111

Spanish Bilingual Helpline
(818) 780-9727

Rape Hotline
(818) 708-1700

Alateen
(213) 387-3158

Info Line
(818) 501-4447

Runaway
1-800-843-5200

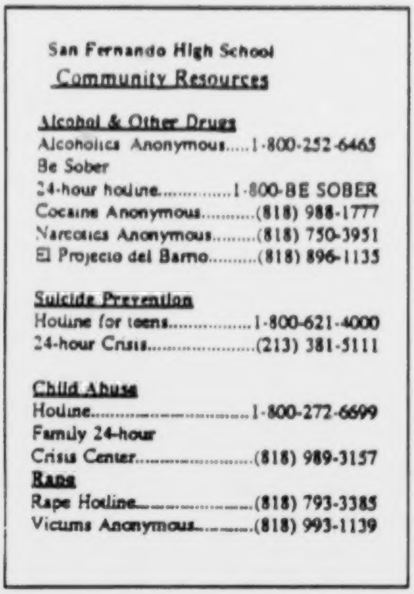
Emergency Counseling

Crisis Management Center
Same day appointments
8101 Sepulveda Blvd.
Van Nuys, 91402
(818) 901-0327 or 782-1985

Olive View Mid-Valley Hospital
14445 Olive Drive
Sylmar 91342
(818) 364-4340 24 hours

FOR ADDITIONAL RESOURCES, SEE THE SCHOOL'S RESOURCE REFERENCE FILE.

Example of a Wallet-Card Developed at a School Site for Students to Carry with Them

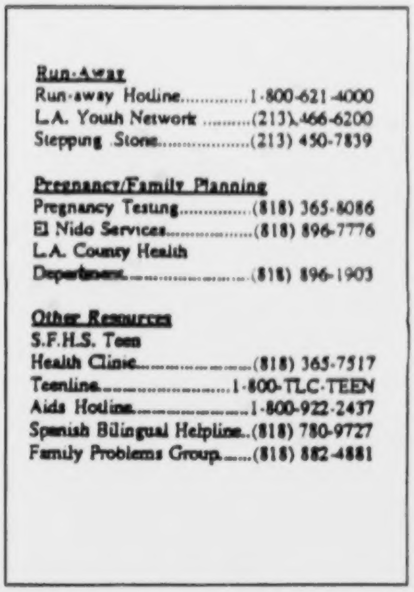


San Fernando High School
Community Resources

Alcohol & Other Drugs
Alcoholics Anonymous.....1-800-252-6465
Be Sober
24-hour hotline..............1-800-BE SOBER
Cocaine Anonymous...........(818) 988-1777
Narcotics Anonymous.........(818) 750-3951
El Projecto del Barrio..........(818) 896-1135

Suicide Prevention
Hotline for teens................1-800-621-4000
24-hour Crisis......................(213) 381-5111

Child Abuse
Hotline.................................1-800-272-6699
Family 24-hour
Crisis Center........................(818) 989-3157
Rape
Rape Hotline.........................(818) 793-3385
Victims Anonymous.............(818) 993-1139



Run-Away
Run-away Hotline.............1-800-621-4000
L.A. Youth Network ....(213) 466-6200
Stepping Stone...................(213) 450-7839

Pregnancy/Family Planning
Pregnancy Testing.............(818) 365-8086
El Nido Services.................(818) 896-7776
L.A. County Health
Department..........................(818) 896-1903

Other Resources
S.F.H.S. Teen
Health Clinic........................(818) 365-7517
Teenline.............................1-800-TLC-TEEN
Aids Hotline.......................1-800-922-2437
Spanish Bilingual Helpline..(818) 780-9727
Family Problems Group......(818) 882-4881

BEST COPY AVAILABLE

Example of One School District's Referral Policy

INTRODUCTION

It is the policy of the District to initiate the referral of parents and pupils to appropriate agencies when a pupil's needs are beyond the scope and/or responsibility of school and District resources. School staff members cooperate with agency personnel in effecting timely and suitable referrals and work together on a continuing basis regarding aspects of the pupils problems which may relate to school adjustment. The following guidelines are to be followed in making such referrals.

I. SCHOOL PERSONNEL RESPONSIBLE FOR REFERRALS

A. The school principal or designee assumes administrative responsibility for the coordination of efforts to help a pupil in the school and for the delegation of community agency referrals to appropriate personnel.

B. Pupil services personnel are trained specifically to assist school staff and parents in the selection and contact of approved community resources providing counseling, health, mental health, and related services.

C. School staff and parents are encouraged to consult with the pupil services personnel assigned to the school for information and assistance in processing referrals (e.g., nurses, counselors, school physicians, psychologists, social workers).

II. SELECTION OF AGENCIES

A. Referrals may be made to:

1. Public tax supported agencies
2. Charitable support based agencies such as those funded under United Way
3. Voluntary non-profit agencies meeting the following criteria:
    a. Directed by a rotating board broadly representative of the community
    b. Not operated on fees alone
    c. Available on a sliding-scale cost to patients
    d. Open to the public without regard to color, race, religion ancestry, or country of natural origin
    e. Licensed by the State Department of Health when mental health services are involved.

B. Referrals shall not be made to:

1. A profit or non-profit proprietary agency. (proprietary: "held in private ownership")
2. Private practitioners or groups of private practitioners.

C. Since the District does not have staff resources to investigate the status or otherwise evaluate community agencies, school personnel should limit referrals to agencies listed by (designated resource book or public information phone or on-line service).

III. PROCESSING OF REFERRALS

A. Most health, counseling and related social service agencies require that the pupil, parent, or guardian make direct application for service. This does not preclude school personnel from assisting in the application process nor from presenting pertinent information to the agency in support of the applicant's request, when authorized by the parent.

B. Complete information about a recommended agency should be given to prospective clients by support services personnel. Such information should include agency program, application procedures, intake process, location, agency hours, telephone number, fees, and other pertinent data.

C. In all agency referrals, consideration should be given to family factors such as:
1. Geographical area
2. Determined needs and services
3. Religious preference
4. Ethnic and/or language factors
5. Financial capability

D. A family's financial resources should be explored discreetly prior to making an appropriate agency referral. A family which has the financial ability to secure private services should consult with the family physician or the referral services provided by professional associations. A family which has its own insurance plan should confer with the plan's insurance consultant.

IV. RELEASE OF PUPIL INFORMATION

Written authorization from parent, guardian, or student (if student is eighteen [18] years of age and living independently of parents, or is an emancipated minor) must be obtained before any school information is released to a community agency regarding a pupil. The same such authorization is required for a community agency to release information to school personnel.

Referral Decisions -- Summary Form

Student's Name or ID # ______________________ Birthdate _______
Date of Request _________

Interviewed by__________________ Date__________

Referred to:

1. On-campus program/resource: ______________________________________
2. Off-campus district resource (e.g., Counseling Center): ______________________
3. Off-campus community agency ______________________________________
4. No referral _________(please indicate why)

PLANS FOR ENROLLMENT

Person to contact_______________________ Phone_________
Location____

Appointment time___________________________

Plans for making initial contact (anticipate any problems):

Back up plans:

If the above plan doesn't work out or if you need additional information or help, contact
___________________ at_______________.

In a week or two, you will be contacted to see if everything worked out as planned. Enter a note into your "tickler" system as a reminder to follow-up.

Resource Aid IID-5

GUIDELINES FOR ACKNOWLEDGING STATUS OF REFERRAL

Rationale:

The referrer and the person to whom an individual is referred both have an ethical responsibility to take steps to ensure the referred individual has been able to make an appropriate contact for needed services.

Thus, the referrer follows-up, if feasible, with the individual or, if necessary, with the person to whom the referral was made.

Similarly, the professional receiving a referral should take steps to inform the referrer whether or not the referred individual has been provided with the recommended services.

Procedures for Communicating Referral Status and Preserving Confidentiality:

Given the intent is to clarify referral status while preserving confidentiality about matters the client does not want others to know, the process of communication is designed to be simple and direct. For instance, in responding to an inquiry from the referrer, one of the following five responses should suffice.

1. The individual that you indicate having referred has contacted me, and I am providing the services for which you referred her/him. Thanks.

2. I had an exploratory session with the individual and referred her/him to ____________. I will be following-up to see if the referral worked out.

3. The individual that you indicate having referred to me has not contacted me.

4. I have tried to make contact with the individual you referred but s/he has not responded to my messages.

5. I had an exploratory session with the individual, but s/he chose not to pursue the services I offer and was not interested in another referral. You may want to recontact her/him.

To facilitate such communication, a form such as the one attached may be useful.

Information Beyond Acknowledging Referral Status:

Except where legal reporting requirements prevail, communications about the nature of the individual's problems and matters discussed require client consent. When communication about such matters may serve the individual's best interests, it is important to convey the matter to the client and to seek a signed release.

REFERRAL FOLLOW-THROUGH FORM

Student's Name: ____________________________ Todays' Date: ______________

____ I was unable to connect with any of the services we discussed.

____ I did connect with (write in the name of the service)

____.

Whether or not you connected with a service, you may want an additional session to discuss your service needs. If so, let us know by checking the following. We will then set up an appointment for you.

____ I would like another session to discuss my needs.

REFERRAL FOLLOW-THROUGH STATUS

TO:

FROM:

We recently referred ____________________ to you.

As part of our case monitoring, we would appreciate your letting us know that this student connected with you.

____

Name of person responding: _________________________________

Todays' Date:_____________

_____ The above named student contacted us on _____________ and was provided appropriate services.

____ We have no record of this student making contact with us.

____

Please return this form to:

Smith High School Health Center
1340 S. Highland Ave.
Johnston, Missouri 90005

School's Record of Response to Request for Assistance in Addressing Concerns about a Student/Family

Name of student ______________________________

Name of staff member who made contact with student __________________________

Date of contact with student ________________

The following are the results of the contact:

Follow-up needed? Yes ___ No ___

If follow-up:

Carried out by ___________________________________ on ____________
(name of staff member)

Results of follow-up:

Was permission given to share information with referrer? Yes ___ No ___

If yes, note the date when the information was shared. ___________

If no, note date that the referrer was informed that her/his request was attended to. _________

Form Used to Aid Follow-Up on Referral Follow-Through

The following form should be used in conjunction with a general calendar system (a "tickler" system) that alerts staff to students who are due for some follow-up activity.

Student's Name: ____________________ Today's Date: _____

DATES FOR FOLLOW-THROUGH MONITORING

Scheduled date for Immediate Follow up_______ (about 2 weeks after referral)

Scheduled date for Long-term *first* Follow up_______

Schedule for *Subsequent* Long-term Follow ups _______ _______ ________

I. Immediate Referral Follow up Information

Date of referral __________ Today's date_____

Immediate Follow up made by________________________ Date_________

________________________ Date_________

________________________ Date_________

Service Need	Agency (name and address)	Phone	Contact person	Appt. time

A. Put a check mark next to those agencies with which contact was made;

B. Put a line through agencies that didn't work out;

C. Put a circle next to agencies still to be contacted.

Indicate any new referrals recommended

Service Need	Agency (name and address)	Phone	Contact person	Appt. time

---

II. Long Term Referral Follow-Up Information

Have identified needs been met?

Contact the student at appropriate intervals (beginning three months after referral) and administer "Follow-up Interview Form -- Service Status."

UNIT IIE: RESPONSE TO STUDENTS' ONGOING PSYCHOSOCIAL AND MENTAL HEALTH NEEDS

Contents *Page*

- Psychosocial Guidance and Support IIE-1
- Psychosocial Counseling IIE-2
- Prevention/Mental Health Education IIE-12

Resource Aids IIE-16

Cited References IIE-23

Exhibits and Resource Aids in Unit IIE

Exhibits

Unit IIE *Page*

20. A Few Thoughts About Engaging Students in a Productive Dialogue IIE-4

21. Some Points About Counseling and Student Motivation IIE-6

Resource Aids

Unit IIE

IIE-1 SBHC Standard Visit Form (Chart Record) -- Mental Health & Psychosocial Concerns IIE-19

IIE-2 Where to Get Resource Materials to Address Barriers to Learning IIE-22

UNIT IIE

Response to Students' Ongoing Psychosocial and Mental Health Needs

The focus here is on three topics:

- psychosocial guidance and support
- psychosocial counseling
- prevention/mental health education

Psychosocial Guidance and Support

Each day many students require a small dose of personalized guidance and support to enhance their motivation and capability for coping with stressors. Others who are involved in therapeutic treatment (e.g., personal counseling, psychotherapy, psychotropic medication) need someone who understands the treatment and can deal with related concerns that arise at school.

Personalized guidance and support is best provided on a regular basis in the classroom and at home. There are great benefits to be gained from any role center staff may play in helping teachers function in ways where they directly provide such support or do so through use of various activities and peer support strategies. Center staff also can play a role in mobilizing and enhancing support from those in the home.

For students registered with the SBHC (see Resource Aid IIC-1 for a sample Registration Form), center staff can play a role as another person for students to contact if something is amiss between what is happening in class and a student's therapeutic regimen. And they can be a good resource to act as a school-site case manager so that there is coordination between the school's efforts to teach and treatment practices.

Guidance and support involves a range of potential activity:

- advising
- advocacy and protection

- providing support for transitions (e.g., orienting new students and connecting them with social support networks, facilitating students with special needs as they transition to and from programs and services)
- mediation and conflict resolution
- promoting and fostering opportunities for social and emotional development
- being a liaison between school and home.
- being a liaison between school and other professionals serving a student

Psychosocial Counseling

The nature and scope of counseling at a center depends on mental health staff time. Most counseling will be short-term; some work with families may be feasible. Informal counseling involves brief encounters with students who drop-in without an appointment or who are contacted, by intent or by chance, at various sites on the campus. Based on screening questionnaire and interview data (see Resource Aids IIC-1 and 2), it will be clear that some student's problems are more than you should try to handle, and you will make the best effort you can to connect them with the right help.

> For those seen at the center, a Standard Visit Form (chart record) of psychosocial problems provides an aid to other center staff who need to be aware of a student's problems and mental health interventions (see Resource Aid IIE-1).

Good counseling builds on the type of caring which is fundamental to all helping interventions. It also encompasses the basics of any good working relationship -- and a bit more. Some basics are highlighted here; these and others are discussed at greater length in a variety of works -- a few of which are referenced at the end of this section.

> In general, counseling requires the ability to carry on a *productive dialogue*, that is, to talk with, not at, others. This begins with the ability to be an active (good) listener and to avoid prying and being judgmental. It also involves knowing when to share information and relate one's own experiences as appropriate and needed. Some thoughts about engaging students in a productive dialogue are outlined on the following pages.

Counseling also requires the ability to create a working relationship that quickly conveys to the student

- *positive value and expectation* (that something of value can and will be gained from the experience)
- *personal credibility* (that the counselor is someone who can help and can be trusted to be keep his or her word, be fair, and be consistent, yet flexible)
- *permission and protection to engage in exploration and change* (that the situation is one where there are clear guidelines saying it is okay and safe to say what's on one's mind).

All this enables the counselor to elicit a student's concerns.

Then, the process requires the ability to respond with

- *empathy, warmth, and nurturance* (e.g., the ability to understand and appreciate what others are thinking and feeling, transmit a sense of liking, express appropriate reassurance and praise, minimize criticism and confrontation)
- *genuine regard and respect* (e.g., the ability to transmit real interest, acceptance, and validation of the other's feelings and to interact in a way that enables others to maintain a feeling of integrity and personal control).

Exhibits II-20 and II-21 highlight matters related to (a) engaging students in a productive dialogue and (b) counseling and student motivation.

Exhibit II-20. A Few Thoughts About Engaging Students in a Productive Dialogue

A few are so nonverbal that referral probably is indicated. Many, however, are just reluctant to talk.

How to Facilitate "Talk"

Quite often, one has to start building a relationship around relatively nonverbal activities, such as responding to a structured set of interview questions dealing with common concerns. In some cases, having students draw themselves or significant others and telling a story about the picture can break the ice and provide some leads.

In general, the focus is on enhancing motivational readiness to dialogue by creating a sense of positive value and expectation for counseling, personal credibility for the counselor, and permission and protection for engaging in exploration for change.

Some specific things to do are

Create a private space and a climate where the student can feel it is safe to talk

Clarify the role and value of keeping things confidential

Avoid interruptions

Start slowly, avoid asking questions, and minimize pressure to talk (the emphasis should be more on conversation and less on questioning and on nonsensitive topics related to the student's main areas of personal interest)

Encourage the student to take the lead

Humor can open a dialogue; sarcasm usually has the opposite effect

Listen with interest

Respond with empathy, warmth, nurturance, and genuine regard and respect

Use indirect leading statement such as "Please tell me more about ...." or direct leading statements such as "You said that you were angry at your parents?"

If needed, use structured tools (surveys, sentence completion) to guide a student (Examples of tools that may be useful are included in the accompanying materials resource packet entitled Screening/Assessing Students: Indicators and Tools.)

Sometimes a list of items (e.g., things that students generally like and dislike at school or after school) can help elicit a student's views and open-up a dialogue

When questions are asked, use open-ended, rather than yes/no questions

Appropriate self-disclosure by a counselor may disinhibit a reluctant student

(cont.)

Exhibit 20. (cont.) **A Few Thoughts About Engaging Students in a Productive Dialogue**

In addition, for groups

Facilitate sharing through various activities (pairing a reluctant student with a supportive peer, having the group share backgrounds)

Clarify that trust, respect, confidentiality, etc. are a function of commitment to the group -- not a matter of stating rules

How to Keep Talk Going

In general, the focus is on maintaining motivation.

Some specific things to do are

Focus on areas of interest, strength, and self-esteem, as well as on analyzing problems

Build on previous discussions by referring to what has been shared

Continue to follow student's leads in analyzing problems and avoid procedures they may perceive as efforts to control them

Continue to convey that the intent is to help not socialize

In addition, for groups

Draw out similarities in experience and problems with a view to encouraging students to see the value of helping each other

Help students understand that giving advice usually is ineffective

Remember:

Short periods of silence are part of the process and should be accommodated.

Exhibit 21. Some Points About Counseling and Student Motivation

Most counseling at a school site is short-term. Some will be informal -- brief encounters with students who drop-in or are encountered somewhere on campus. All encounters have the potential to be productive as long as one attends to student motivation as key antecedent and process conditions and as an important outcome concern.

(1) **Motivation is a key antecedent condition.** That is, it is a prerequisite to functioning. Poor motivational readiness may be (a) a cause of inadequate and problem functioning, (b) a factor maintaining such problems, or (c) both. Thus, strategies are called for that can result in enhanced motivational readiness (including reduction of avoidance motivation) -- so that the student we are trying to help is mobilized to participate.

(2) **Motivation is a key ongoing process concern.** Processes must elicit, enhance, and maintain motivation -- so that the student we are trying to help stays mobilized. For instance, a student may value a hoped for outcome but may get bored with the processes we tend to use.

With respect to both readiness and ongoing motivation, conditions likely to lead to negative motivation and avoidance reactions must be avoided or at least minimized. Of particular concern are activities students perceives as unchallenging/ uninteresting, overdemanding, or overwhelming and a structure that seriously limits their range of options or that is overcontrolling and coercive. Examples of conditions that can have a negative impact on a student's motivation are excessive rules, criticism, and confrontation.

(3) **Enhancing intrinsic motivation is a basic outcome concern.** A student may be motivated to work on a problem during counseling but not elsewhere. Responding to this concern requires strategies to enhance stable, positive attitudes that mobilize the student to act outside the intervention context and after the intervention is terminated.

Essentially, good counseling reflects the old maxim of "starting where the student is." But more is involved than matching the student's current capabilities. As suggested, attending to a student's motivational levels is also critical. Thus, it is the counselor's responsibility to create a process that will be a good fit with the student's capabilities *and* motivation.

> The less one understands the background and experiences that have shaped a student, the harder it may be to create a good fit. This problem is at the root of concerns about working with students who come from different cultures. It is, of course, a concern that arises around a host of individual differences.

As discussed in the unit on working with others, efforts to create effective working relationships require a breadth and depth of knowledge, skills, and positive attitudes.

Counseling aims at enabling students to increase their sense of competence, personal control, and self-direction -- all with a view to enhancing ability to relate better to others and perform better at school. When a counseling relationship is established with a student, care must be taken not to undermine these aims by allowing the student to become dependent and overrely on you. Ways to minimize such dependency include

- giving advice rarely, if at all
- ensuring that the student takes personal responsibility for her or his efforts to deal with problems and assumes credit for progress
- ensuring that the student doesn't misinterpret your efforts to help or lose sight of the limits on your relationship
- helping the student identify when it is appropriate to seek support and clarifying a wide range of ways to do so.
- planning a careful transition for termination

And be sure to avoid the "Rescue Trap."

The Rescue Trap

So you want to help! That's a nice attitude, but it can sometimes lead to trouble -- especially if you aren't aware of the interpersonal dynamics that can arise in helping relationships. Several concerns have been discussed in the psychotherapy literature. One that almost everyone has experienced has been described as a "rescue."

> A *rescue* is helping gone astray. Rescues encompass a cycle of negative interpersonal transactions that too commonly arise when one person sets out to intervene in another's life in order to help the person.

Think about a time when someone you know told you about a problem she or he was having. Because the person seemed not to know how to handle the problem, you offered some suggestions. For each idea you offered, the person had an excuse for why it wouldn't work. After a while, you started to feel frustrated and maybe even a bit angry at the person. You may have thought or said to the individual, "You don't really want to solve this problem; you just want to complain about it."

> In rescue terms, you tried to help, but the person didn't work with you to solve the problem. The individual's failure to try may have frustrated you, and you felt angry and wanted to tell the person off. And that may only have been the beginning of a prolonged series of unpleasant interpersonal transactions related to the situation.

If you were ever in such a situation, you certainly experienced the price a person pays for assuming the role of rescuer. Of course, you know you didn't mean to become involved in a negative set of transactions. You wanted to help, but you didn't realize fast enough that the individual with the problem wasn't about to work with you in order to solve it. And you didn't know what to do when things started going wrong with the process.

> If you can't remember a time you were the rescuer, you may recall a time when someone tried to rescue you. Perhaps your parents, a teacher, or a good friend made the mistake of trying to help you when or in ways you didn't want to be helped. The person probably thought she or he was acting in your best interests, but it only made you feel upset -- perhaps increased your anxiety, frustration, anger, and maybe even made you feel rather inadequate.

Rescue cycles occur frequently between teachers and students and parents and their children. Well-intentioned efforts to help usually begin to go astray because someone tries to help at a time, in a way, or toward an end the person to be helped doesn't experience as positive.

> Let's take the example of a teacher, Ms. Benevolent, and one of her students, Jack. Ms. Benevolent is a new teacher who has just begun to work with a group of students with learning problems. She sees her students, Jack included, as handicapped individuals, and she wants so much to help them.

(cont.)

The Rescue Trap (cont.)

Unfortunately, Jack doesn't want to be helped at the moment. And when he doesn't want to be helped, Jack is not mobilized to work on solving his problems. Indeed, efforts to intervene often make him feel negative toward his teacher and even toward himself. For example, he may feel anger toward Ms. Benevolent and feel guilty and incompetent because of not working to solve his learning problem. Ironically, not only doesn't he see the teacher as a helper, he also feels victimized by her. In response to these feelings, he behaves in a self-protective and defensive manner. Sometimes he even assumes the stance of being a helpless victim. ("How can you expect me to do that? Don't you know I have a learning handicap?")

> Because Jack continues to respond passively or in ways the teacher views as inappropriate, eventually she becomes upset and starts to react to him in nonhelpful and sometimes provocative ways. She may even have a tendency to subtly persecute Jack for not being appreciative of all her efforts to help him. ("You're just lazy." "If your attitude doesn't improve, I'm going to have to call your parents.")

The more the teacher pushes Jack to act differently and attacks him for acting (and feeling) as he does, the more likely he is to feel victimized. However, sooner or later he is likely to become angry enough about being victimized that he reacts and counterattacks. That is, if he can, he shifts from the role of victim to the role of persecutor.

> When interveners who see themselves as benevolent helpers are attacked, they may tend to feel victimized. Indeed, the experience of having been unsuccessful in helping may be sufficient to make some interveners feel this way. As Jack shifts to a persecuting role, Ms. Benevolent adopts a victim role. ("After all I've done for you, how can you treat me this way?" "All I'm trying to do is help you.")

Of course, interveners are unlikely to remain victims for very long if they can help it. If they do, "burn out" may well occur.

> Sometimes, after the fighting stops, the parties make up, and the intervener starts to see the other person's behavior as part of the individual's problems and tries once more to help. However, if great care is not taken, this just begins the whole cycle again.

How can the cycle be avoided or broken? One of the essential ingredients in a good helping relationship is a person who wants to be helped. Thus, it is necessary to be sure that the person is ready and willing to pursue the type of help that is being offered.

> If the person is not ready and willing, interveners are left with only a few options. For one, the intervener can choose to give up trying to help. Or if it is essential that the individual be *forced* to do something about the problem, the intervener can adopt a socialization strategy. Or effort can be made to explore with the individual whether he or she wants to think about accepting some help.

In effect, this last approach involves trying to establish motivational readiness.

Regardless of how long you have seen a student for counseling, if a relationship has been established, you will need to deal with *termination.* This involves discussing the fact that the counseling is coming to an end, exploring any anxiety the student has about this, and reassuring the student about how s/he can deal with subsequent problems.

> If the student is being referred for more counseling, you will want to provide support for a smooth transition, including clarifying what you should share with the new counselor. (This is a good reason for keeping a confidential Chart Record on the student.)

If the student will not be receiving additional support, you will want to try to connect her or him with an appropriate support network to draw upon (e.g., staff, peers, family).

> If feasible, extend an invitation asking the student to let you know periodically how things are going.

Finally, a cautionary note about taking care of your own mental health as well as that of other staff in the center and throughout the school:

> No one needs to tell anyone who works in a school setting how stressful it is to come to work each day. Stress is the name of the game and, unfortunately, some working conditions are terribly stressful.

Some of the stress comes from working with troubled and troubling youngsters. Some is the result of the frustration that arises when everyone works so hard and the results are not good enough.

> In schools, the end of a school year may result in many students leaving all at the same time. For the counselor, this may produce a major sense of loss that adds to the frustrations of the job and contributes to feeling "burnt out."

> > Over time, all the stress combines and can lead to demoralization, exhaustion, and burnout.

The cost of ignoring staff stress is that the programs and services they offer suffer because of less than optimal performance by staff who stay and frequent personnel turnover. As with family members, center and other school staff find it difficult to attend to the needs of students when their own needs are going unattended.

> From this perspective, any discussion of mental health in schools should address ways to help staff reduce the sources of stress and establish essential social and emotional supports.

Such supports are essential to fostering awareness and validation, improving working conditions, developing effective attitudes and skills for coping, and maintaining balance, perspective, and hope.

Mother to son: *Time to get up and go to school.*

Son: *I don't want to go. It's too hard and no one there likes me.*

Mother: *But You have to go – you're the principal.*

A Note on Diagnosis

> Formal differential diagnosis plays a major role in distinguishing true psychopathology from every day psychosocial concerns. Diagnostic classification also is demanded by third party payers. The most widely used system for diagnosing mental disorders throughout the U.S.A. is the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Appendix II-2 provides a brief summary of the categories commonly used with children and adolescents.

BEST COPY AVAILABLE

Prevention/Mental Health Education

Educative functions range from disseminating mental health information to actual course instruction related to positive social and emotional development and wellness.

Every school needs to disseminate information that helps protect, promote, and maintain the well-being of students with respect to both physical but mental health. Center staff usually play a major role in disseminating physical health related information. It does not take much imagination to see how important it is that such activity encompass mental health. This includes providing highly visible information related to prevention and correction:

- positive opportunities for recreation and enrichment
- opportunities to earn money
- how to stay healthy -- physically and mentally (this includes instruction using curricula on special topics such as social skills and interpersonal relationships, substance abuse, violence prevention, physical and sexual abuse prevention, sex education, and so forth)
- early identification of problems
- what a student/parents should do when problems arise
- warm lines and hotlines
- services on- and off-campus.

Promoting healthy development is one of the keys to preventing mental health and psychosocial problems. For schools, the need is to maintain and enhance health and safety and hopefully do more.

This requires programs that

inoculate through providing positive and negative information, skill in instruction,and fostering attitudes (e.g., using facets of health education -- physical and mental -- to build resistance and resilience). Examples of problems addressed with a preventive focus are substance abuse, violence, pregnancy, school dropout, physical and sexual abuse, suicide

directly facilitate development in all areas (physical, social, emotional) and in ways that account for differences in levels of development and current developmental demands. Examples of arenas for activity are parent education and support, day care, preschool, early education, elementary classrooms, recreation and enrichment programs

identify, correct, or at least minimize physical and mental health and psychosocial problems as early after onset as is feasible

Appreciation of the developmental demands at different age levels is helpful, and awareness of an individual's current levels of development is essential. Basic textbooks provide guides to understanding developmental tasks.

Examples of Major Developmental Tasks

Toddlers (2-4)	Locomotion and increasing control over gross motor skills Early speech Playing with others Beginning of impulse control
Early school age (4-6)	Sex-role identification Increasing control over fine motor skills Acquisition of basic language structure Beginning sense of morality Playing with others in groups
Middle school age (6-12)	Establishing close friendships Strengthening sense of morality Increasing listening skills Ability to use language in multifaceted and complex ways Academic achievement Teamwork Self-evaluation
Early adolescence (12-18)	Accepting one's physique Emotional development Lessening emotional dependence on parents Widening peer relationships Choosing and preparing for higher education/occupation Gender identity, sex role patterns, and sexual relationships Acquiring socially responsible values and behavior patterns

One way to think about all this is to remember that the normal trends are for school-age youngsters to strive toward feeling *competent, self-determining*, and *connected with others*. When youngsters experience the opposite of such feelings, the situation may arouse anxiety, fear, anger, alienation, a sense of losing control, a sense of impotence, hopelessness, powerlessness. In turn, this can lead to externalizing (aggressive, "acting out") or internalizing (withdrawal, self-punishing, delusional) behaviors.

> While efforts to facilitate social and emotional development focus on enhancing knowledge, skills, and attitudes, from a mental health perspective the intent is to enhance an individual's feelings of competence, self-determination, and connectedness with others.

Areas of Focus in Enhancing Healthy Psychosocial Development

Responsibility and integrity
(e.g., understanding and valuing of societal expectations and moral courses of action)

Self-esteem
(e.g., feelings of competence, self-determination, and being connected to others)

Social and working relationships
(e.g., social awareness, empathy, respect, communication, interpersonal cooperation and problem-solving, critical thinking, judgement, and decision making)

Self-evaluation/self-direction/self-regulation
(e.g., understanding of self and impact on others, development of personal goals, initiative, and functional autonomy)

Temperament
(e.g., emotional stability and responsiveness)

Personal safety and safe behavior
(e.g., understanding and valuing of ways to maintain safety, avoid violence, resist drug abuse, and prevent sexual abuse)

Health maintenance
(e.g., understanding and valuing of ways to maintain physical and mental health)

Effective physical functioning
(e.g., understanding and valuing of how to develop and maintain physical fitness)

Careers and life roles
(e.g., awareness of vocational options, changing nature of sex roles, stress management)

Creativity
(e.g., breaking set)

During the instructional day, the curricula in many classes touches upon matters related to positive social and emotional development and wellness. In addition, some schools actually have incorporated mental health as a major facet of health education. And school staff are involved each day in dealing with matters related to mental health and psychosocial concerns.

> Related to these matters, efforts should be made to capitalize on the center staffs' strengths by facilitating ways for them to play a direct role with students as part of a school's efforts to provide comprehensive health education and an indirect role by participating in developing the capacity of other staff to address these matters.

In addition, center staff can play a role in a variety of open-enrollment programs designed to foster positive mental health and socio-emotional functioning. They can also help establish strategies to change the school environment in ways that make it more inviting and accommodating to students. This involves participation in staff development, but even more, it requires working with school staff to restructure the school so that it effectively promotes a sense of community. Examples include establishing welcoming programs for new students and families and strategies to support other transitions, developing *families* of students and teachers to create schools within schools, and teaching peers and volunteer adults to provide support and mentoring. Intervening at this environmental level also encompasses working with community agencies and businesses to enhance the range of opportunities students have with respect to recreation, work, and community service.

> Effective open-enrollment and prereferral intervention programs and environment change strategies can minimize the number of mild to moderate problems that develop into severe ones. This reduces the number in need of specialized interventions and helps reserve such help for those who inevitably require them.

A variety of materials are available to support your efforts to respond to students' mental health and psychosocial concerns (see Resource Aid IIE-2).

How Good are School-Based Programs?

> **An extensive literature reports positive outcomes for psychological interventions available to schools. Some benefits have been demonstrated not only for schools (e.g., better student functioning, increased attendance, less teacher frustration), but for society (e.g., reduced costs related to welfare, unemployment, and use of emergency and adult services).[1]**
>
> **At the same time, it is clear that school-based applications must be pursued cautiously. With respect to individual treatments, positive evidence generally comes from work done in tightly structured research situations; unfortunately, comparable results are not found when prototype treatments are institutionalized in school and clinic settings. Similarly, most findings on classroom and small group programs come from short-term experimental studies (usually without any follow-up phase). It remains an unanswered question as to whether the results of such projects will hold up when the prototypes are translated into wide-spread applications (see Adelman & Taylor, 1997; Durlak, 1995; Elias, 1997; Weisz, Donenberg, Han, & Weiss, 1995). Available evidence is insufficient to support any policy that restricts schools to use of empirically supported interventions, and the search for better practices remains a necessity.**

---

[1] There are too many references to cite here, but a bit of an overview can be garnered from Adelman and Taylor (1993), Albee and Gullotta (1997), Borders and Drury (1992), Carnegie Council on Adolescent Development (1988), Dryfoos (1990, 1994, in press), Durlak (1995), Duttweiler (1995), Goleman (1995), Kazdin (1993), Larson (1994), Schorr (1988), Slavin, Karweit, and Wasik (1994), Thomas and Grimes (1995).

RESOURCE AIDS

A. Resource Aids Included Here

Appendix II-2

About the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, 1994)

This appendix provides a brief summary of the DSM-IV categories commonly used with children and adolescents.

Resource Aid IIE-1

SBHC Standard Visit Form (Chart Record) -- Mental Health and Psychosocial Concerns

Provides an example of a checklist format for chart recording that can be easily coded for computer use..

Resource Aid IIE-2

Where to Get Resource Materials to Address Barriers to Learning

Describes a Resource Aid Packet that contains a sampling of organizations and publishers that offer a variety of materials relevant to addressing students' psychosocial and mental health concerns. Included is information about resources available upon request and/or purchase. A few example materials are included here as samples of what is available.

B. Related Resource Aid Packets Available from Our Center

Dropout Prevention

Highlights intervention recommendations and model programs, as well as discussing the motivational underpinnings of the problem.

Learning Problems and Learning Disabilities

Identifies learning disabilities as one highly circumscribed group of learning problems, and outlines approaches to address the full range of problems.

Teen Pregnancy Prevention and Support

Covers model programs and resources and offers an overview framework for devising policy and practice.

Cultural Concerns in Addressing Barriers to Learning

Highlights concepts, issues and implications of multiculturalism/cultural competence in the delivery of educational and mental health services, as well as for staff development and system change. This packet also includes resource aids on how to better address cultural and racial diversity in serving children and adolescents.

Students and Psychotropic Medication: The School's Role

Underscores the need to work with prescribers in ways that safeguard the student and the school. Contains aids related to safeguards and for providing the student, family, and staff with appropriate information on the effects and monitoring of various psychopharmacological drugs used to treat child and adolescent psycho-behavioral problems.

Substance Abuse

Offers some guides to provide schools with basic information on widely abused drugs and indicators of substance abuse. Includes some assessment tools and reference to prevention resources.

Where to Get Resource Materials to Address Barriers to Learning

Offers school staff and parents a listing of centers, organizations, groups, and publishers that provide resource materials such as publications, brochures, fact sheets, audiovisual & multimedia tools on different mental health problems and issues in school settings.

Clearinghouse Catalogue

Our Clearinghouse contains a variety of resources relevant to the topic of mental health in schools. This annotated catalogue classifies these materials, protocols, aids, program descriptions, reports, abstracts of articles, information on other centers, etc. under three main categories: policy and system concerns, program and process concerns, and specific psychosocial problems. (Updated regularly)

Consultation Cadre Catalogue

Provides information for accessing a large network of colleagues with relevant experiences related to addressing barriers to student learning and mental health in schools. These individuals have agreed to share their expertise without charging a fee. The catalogue includes professionals indicating expertise related to major system and policy concerns, a variety of program and process issues, and almost every type of psychosocial problem. (Updated regularly)

Catalogue *of Internet Sites Relevant to Mental Health in Schools*

Contains a compilation of internet resources and links related to addressing barriers to student learning and mental health in schools. (Updated regularly)

Least Intervention Needed:
Toward Appropriate Inclusion of Students with Special Needs

Highlights the principle of *least intervention needed* and its relationship to the concept of *least restrictive environment*. From this perspective, approaches for including students with disabilities in regular programs are described.

Parent and Home Involvement in Schools

Provides an overview of how home involvement is conceptualized and outlines current models and basic resources. Issues of special interest to under-served families are addressed.

Understanding and Minimizing Staff Burnout

Addresses various sources and issues of burnout and compassion fatigue among school staff and mental health professionals. Also identifies ways to reduce environmental stressors, increase personal capability, and enhance social support to prevent burnout.

SCHOOL-BASED HEALTH CENTER

Standard Visit Form (Chart Record) -- Mental Health & Psychosocial Concerns

Student's Center ID# ____________ Visit Date ___/___/____ Intervener ______________

Consent Form: Allows for this service ___ Registration Date: ___/___/___

Student Name: ______________________________________ (Last, First, Middle) SEX: ___ (M/F)

BIRTHDATE: __/__/__ Age:___ Grade:___

Ethnicity:__________________ Primary Language:__________

Presenting Problem for Mental Health services:

Change in status since last visit: positive ___ negative ___ no change ___

Clinician's view of Problem:		**Severity** (of prob. or reaction				**Duration** (onset or length)		
		Very Sev. 1	Sev. 2	Not too 3	Not at all 4	0-3 mos	4 mo. -1 yr.	more than a y
I. Emotional State								
A. Sad	___	___	___	___	___	___	___	___
B. grief	___	___	___	___	___	___	___	___
C. suicidal thinking	___	___	___	___	___	___	___	___
D. fearful	___	___	___	___	___	___	___	___
E. anxious	___	___	___	___	___	___	___	___
F. low esteem	___	___	___	___	___	___	___	___
G. aggression/ anger	___	___	___	___	___	___	___	___
H. other (specify) ___________	___	___	___	___	___	___	___	___

***II. Relationship Problems*:**	separation	conflict	1	2	3	4	0-3 mos	4 mo. -1 yr.	more than a y
A. family	___	___	___	___	___	___	___	___	___
B. peers	___	___	___	___	___	___	___	___	___
C. close friend	___	___	___	___	___	___	___	___	___
D. teachers	___		___	___	___	___	___	___	___
E. other (specify) ___________	___		___	___	___	___	___	___	___

Clinician's view of Problem:		**Severity** (of prob. or reaction				**Duration** (onset or leng		
		Very Sev. 1	Sev. 2	Not too 3	Not at all 4	0-3 mos	4 mo. -1 yr.	more than a y
III. School Functioning:								
A. trouble adjusting to new school	___	___	___	___	___	___	___	___
B. learning problems	___	___	___	___	___	___	___	___
C. unmotivated at school	___	___	___	___	___	___	___	___
D. behavior problems	___	___	___	___	___	___	___	___
E. considering dropping out	___	___	___	___	___	___	___	___
F. other (specify)								
____________	___	___	___	___	___	___	___	___
IV. Psychological support needed for other problems:								
A. diet (weight loss, anorexia, bulimia)	___	___	___	___	___	___	___	___
B. sexual behavior	___	___	___	___	___	___	___	___
C. pregnancy	___	___	___	___	___	___	___	___
D. assertiveness	___	___	___	___	___	___	___	___
E. somatic complaints	___	___	___	___	___	___	___	___
F. sleep problems	___	___	___	___	___	___	___	___
G. gender concerns	___	___	___	___	___	___	___	___
H. other (specify)								
____________	___	___	___	___	___	___	___	___
V. Abuse/Neglect by others:								
A. physical	___	___	___	___	___	___	___	___
B. sexual	___	___	___	___	___	___	___	___
C. victimization	___	___	___	___	___	___	___	___
D. emotional	___	___	___	___	___	___	___	___
E. neglect	___	___	___	___	___	___	___	___
F. other (specify)								
____________	___	___	___	___	___	___	___	___
VI. Substance Abuse:								
A. drugs	___	___	___	___	___	___	___	___
B. alcohol	___	___	___	___	___	___	___	___
C. other (specify)								
____________	___	___	___	___	___	___	___	___

Clinician's view of Problem:		**Severity** (of prob. or reaction				**Duration** (onset or length)		
		Very Sev.	Sev.	Not too	Not at all	0-3 mos	4 mo. -1 yr.	more than a yr.
VII. Transition Problems:		1	2	3	4			
A. change in residence	___	___	___	___	___	___	___	___
B. family changes (e.g., birth, death, separation	___	___	___	___	___	___	___	___
C. changes at school (e.g., new school, new programs)	___	___	___	___	___	___	___	___
D. other (specify)								
___________	___	___	___	___	___	___	___	___

VIII. Other: (specify)

Apparent Cause

Intervention Plan	*Individual*	*Group*
Therapy/counseling with Center Mental Health staff	___	___
Work with Center Health Educator	___	___

Other (specify) ____

Impact of the Session Just Conducted

very productive ____ unproductive ____ somewhat productive ___ uncertain ___

Any changes in Intervention Plan (including referrals)?

Where to Get Resource Materials to Address Barriers to Learning,

Among the various ways the Center for Mental Health in Schools at UCLA packages resources are our *Resource Aid Packets. Resource Aid Packets* are designed to complement our series of Introductory Packets. These resource aids are a form of *tool kit.* One such Resource Aid, entitled *Where to Get Resource Materials to Address Barriers to Learning,* is designed to provide a sampling of organizations and publishers that offer a variety of materials relevant to addressing students' psychosocial and mental health concerns. Included is information about resources available upon request and/or purchase. The packet is divided into three sections:

> Section I identifies national centers and clearinghouses, professional organizations and foundations that provide printed documents such as fact sheets, brochures, pamphlets, posters, etc. that are useful for educational programs and campaigns. Most of the places listed in this section supply bulk materials for free or require a minimum recovery fee.
>
> Section II lists publishers and distributors of books, curriculum modules/packages, posters, multimedia tool kits (e.g. audio/videotapes and educational software programs), educational games, and so forth that serve as supplementary aids and strategies for classroom learning, as well as counseling purposes. Some also offer in-service training materials for staff development in dealing with the students' psychosocial problems. In general, the materials listed in this section are available for purchase.
>
> Finally, Section III contains sample fact sheets provided by organizations listed in section I.

Cited References

Adelman, H.S., & Taylor (1997). Toward a scale-up model for replicating new approaches to schooling. *Journal of Educational and Psychological Consultation, 8,* 197-230.

Adelman, H.S., & Taylor, L. (1993). *Learning problems and learning disabilities: Moving forward.* Pacific Grove, CA: Brooks/Cole.

Albee, G.W. & Gullotta, T.P. (Eds.), (1997). *Primary prevention works.* Thousand Oaks, CA: Sage.

Borders, L.D., & Drury, S.M. (1992). Comprehensive school counseling programs: A review for policymakers and practitioners. *Journal of Counseling & Development, 70*, 487-498.

Carnegie Council on Adolescent Development, (1988). Review of school-based health services. New York: Carnegie Foundation.

Dryfoos, J.G. (1990). *Adolescents at risk: Prevalence and prevention.* London: Oxford University Press.

Dryfoos, J.G. (1994). *Full-service schools: A revolution in health and social services for children, youth, and families.* San Francisco: Jossey-Bass.

Dryfoos, J. (in press). *Safe passage: Making it through adolescence in a risky society.* New York: Oxford University Press.

Durlak, J.A. (1995). *School-based prevention programs for children and adolescents.* Thousand Oaks, CA: Sage.

Duttweiler, P.C. (1995). *Effective strategies for educating students in at risk situations.* Clemson, SC: National Dropout Prevention Center.

Elias, M.J. (1997). Reinterpreting dissemination of prevention programs as widespread implementation with effectiveness and fidelity. In R.P. Weissberg, T.P. Gullotta, R.L. Hamptom, B.A. Ryan, & G.R. Adams (Eds.), *Establishing preventive services*, pp. 253-289. Thousand Oaks, CA: Sage.

Goleman, D. (1995). *Emotional Intelligence*. New York: Bantam Books, Inc.

Kazdin, A.E. (1993). Adolescent mental health: Prevention and treatment programs. *American Psychologist, 48*, 127-141.

Larson, J. (1994). Violence prevention in the schools: A review of selected programs and procedures. *School Psychology Review, 23*, 151-164.

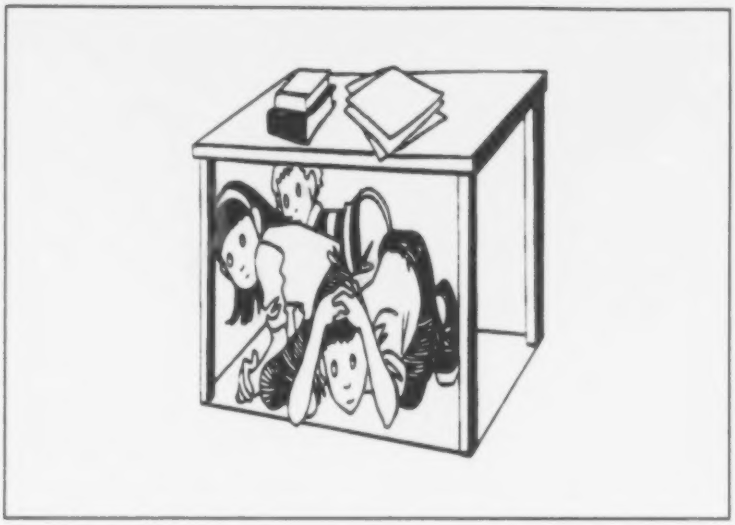
Schorr, L.B. (1988). *Within our reach: Breaking the cycle of disadvantage*. New York: Doubleday.

Slavin, R., Karweit, N., & Wasik, B. (1994). *Preventing early school failure: Research on effective strategies.* Boston: Allyn & Bacon.

Thomas, A., & Grimes, J. (Eds.) (1995). *Best practices in school psychology -- III.* Washington, DC: National Association for School Psychologists.

Weisz, J.R., Donenberg, G.R., Han, S.S., & Weiss, B. (1995). Bridging the gap between laboratory and clinic in child and adolescent psychotherapy. *Journal of Consulting and Clinical Psychology, 63*, 699-701.

Module II: *Working with Students Who Come to the Center*



UNIT IIF: RESPONDING TO CRISES AT A SCHOOL

Contents *Page*

- School-Based Crisis Intervention: Overview IIF-2
  - >Who Should Be Responsible? IIF-4
  - >Planning for Crises IIF-5
  - >A School-Based Crisis Team IIF-10
  - >Crisis Aftermath Subteams IIF-15
  - >Maintaining Crisis Response Capability and School Awareness IIF-17
- Psychological First Aid IIF-18
- Addressing Specific Areas of Concern Related to Crises IIF-22

Resource Aids IIF-23

A Few Related References IIF-48

Exhibits and Resource Aids in Unit IIF

Exhibits

Unit IIF

	Page
22. Scope of Crisis Events and Intervention Phases	IIF-8
23. Major Facets of Crises Response	IIF-9
24. A Few General Principles Related to Responding to Crises	IIF-19

Resource Aids

Unit IIF

IIF-1	District Policy Considerations	IIF-25
IIF-2	Crisis Response Checklist	IIF-26
IIF-3	Some Key Considerations in Establishing a System for School-Based Crisis Response	IIF-30
IIF-4	Informing the Students and Staff	IIF-34
IIF-5	A Few Indicators of Reactions to Trauma	IIF-37
IIF-6	A Crisis Screening Interview	IIF-39
IIF-7	Aftermath Classroom Activities	IIF-42

Unit IIF
Responding to Crises at a School

David Schonfeld, Marsha Kline, and their colleagues at Yale note:

> Schools are no longer the "islands of safety" that they once were believed to represent, as street crime, random violence, and large-scale accidents pervade schools in all parts of the country and affect children of all ages on a regular basis . . . . In a survey conducted in 1978 in two public high schools in Kansas City, Kansas, nearly 90% of the students reported having experienced the death of a grandparent, aunt, uncle, sibling, or someone else they cared about, 40% of the students reported the death of a close friend of their, own age, and approximately 20% had witnessed a death. In a 1990 survey involving urban high school students, half the students reported that they knew someone who had been murdered, 37% had witnessed a shooting, and 31 %, a stabbing (Pastore *et al.*, 1991). In another survey of students attending 10 inner-city high schools, rates of direct gun-related victimization were alarmingly high; 20% of the students reported having been threatened with a gun and 12% had been the target of a shooting (Sheley *et al.*, 1992). The exposure to community violence and violent deaths is not restricted to adolescents and adults .... In a 1992 study conducted in an urban pediatric continuity clinic in Boston, 7% of the children had witnessed a shooting or stabbing before the age of 6 years . . . . As schools face an escalating number of crises, the probability that any child or group of children will experience violence or sudden death of a friend and/or loved one is increasing.
>
> These events often require a response from the school in order to address the children's developmental needs during times of crisis and uncertainty. These crisis periods can disrupt learning, at a minimum, and also have the potential to retard children's emotional and psychological adjustment to the event and impair their subsequent development.
>
> Despite the overwhelming need for a crisis prevention and response plan, many schools remain unprepared. . . . School systems, therefore, need to develop and institute a coordinated and systematic response plan before another crisis occurs. School systems, however, may be reluctant to consider the potential for crises to occur and may deny the need for crisis intervention services . . . . This organizational denial of the need for crisis intervention services may also be reflected in an organizational push to resolve a crisis prematurely -- "to get things back to normal as soon as possible." . . . . Schools increasingly need an effective crisis prevention and response plan in order to avert disasters where possible and to ameliorate their impact on children when the disasters cannot be avoided . . . .

All center staff will find it wise to prepare to cope with common crisis events that may arise for students. Such crises usually involve outside threats to a client's health and safety and threats by a client to hurt self and/or others. Initially, the need is for training in how to respond to students who are overly aggressive toward staff or present with concerns about suicide or abuse. Eventually, steps can be taken to integrate center staff into school procedures for comprehensive crises intervention.

School-Based Crisis Intervention: Overview

In this section, you will find a brief, basic discussion of the need for a school to be able to plan and implement a response to crises. The material can be used to raise staff awareness of need and as shared reading prior to initiating staff training. The following topics are explored:

- Who Should Be Responsible?
- Planning for Crisis
- A School-Based Crisis Team
- Crisis Aftermath Subteams
- Maintaining Crisis Response Capability and School Awareness

SCHOOL-BASED CRISIS INTERVENTION

Crises are dangerous opportunities.

Chinese saying

Crisis, emergency, disaster, catastrophe, tragedy, trauma -- all are words heard too frequently at schools today. Almost every school has had a major crisis; every school is likely to have one. Besides natural disasters such as earthquakes and fires, students experience violence and death related to the suicide of friends, gang activity, snipers, hostage-taking, and rape. Some students react with severe emotional responses -- fear, grief, post traumatic stress syndrome. Moreover, such experiences and other events that threaten their sense of worth and well-being can produce the type of intense personal turmoil that leads students to think about hurting themselves or others.

> If no effort is made to intervene, emotional reactions may interfere with a student's school and home performance, can be imminently life threatening, or may be the start of long-term psychosocial problems. And, when a significant portion of the student body is affected, major facets of a school's functioning are likely to be jeopardized.

As used here, the term, school-based crisis intervention, refers to a range of responses schools can plan and implement in response to crisis events and reactions. All school-based and school-linked staff can play an important role in crisis intervention.

Who Should Be Responsible?

Given the complexity of crisis events and reactions, planning and implementing school-based crisis intervention require special expertise (e.g., how to deal with natural disasters as contrasted to dealing with gang violence or suicide, how to plan for crowd management, rumor control, aftermath counseling, prevention). Thus, individuals and subgroups with diverse expertise need to be involved, and all who are involved usually need additional specialized inservice training.

> Whatever happens at the school level is shaped by district policy and procedural guidelines. In most instances, the district's administration will have provided the school with detailed guidelines for handling major disasters during the emergency itself and in the immediate aftermath (see Resource Aid IIF-1). Such guidelines also should clarify available district support resources (e.g., district crisis teams, medical and counseling services).

It is rarer for districts to have addressed, in the same detail, policies and procedures for what to do in the days and weeks that follow the event and what to do to improve future responses or to prevent future occurrences where feasible.

> Regardless of what guidelines the district provides, it falls to the school to develop a specific operational plan and to identify and prepare personnel to carry it out. This might all be done by a school's administration. That is, they might assume the task of planning and then identifying and assigning specific duties to staff (e.g., school nurse, specific teachers, psychologist). However, as noted above, the diversity of expertise required suggests a broad-based approach to planning and implementation. Thus, schools probably will find the concept of a school-based crisis team useful. And SBHC staff can play a key role in making certain such a team is operational and well-trained.

The proper handling of school-wide crises is essential to minimizing negative impact on learning and mental health. A comprehensive crisis intervention approach provides ways for school personnel, students, and parents to return to normalcy as quickly as feasible, address residual (longer-term) psychosocial problems, and explore preventive measures for the future. To achieve these desirable outcomes, a school district must adopt, implement, and institutionalize a set of crisis intervention procedures.

Developing procedures for a school-based response to crises requires mechanisms for initial planning, implementation, and ongoing evaluation and change. Effective mechanisms to accomplish these tasks include:

- a school-based planning committee (whose efforts hopefully are augmented by district support staff)

- a school-based crisis team

Note: The planning and crisis team may be one and the same or may be two separate and coordinated groups.

Rather than asking one person to take responsibility for organizing for crises, the school administration is well-advised to form a small planning committee of school staff. The individuals asked to serve, by role and interest, should be ready to evolve a working plan and become the nucleus of a school-based crisis team. They also should be given appropriate released or compensated time, support, recognition, and appreciation.

In the best of circumstances, the district should provide not only policy and procedural guidelines, but support staff to help the school planning committee (including SBHC staff) formulate a specific plan, organize and train the crisis team, and coordinate with relevant district and community resources.

Planning for Crises

Every school needs a plan for school-based crisis intervention. It is important to anticipate the specifics of what may happen and how to react. Once the need for a plan is recognized, it underscores the need to identify *who* will be responsible for planning responses to crisis events.

Once identified, planners of school-based crisis intervention can work out criteria, procedures, and logistics regarding such general matters as

- who will assume what roles and functions in responding to a crisis
- what types of events the school defines as a crisis warranting a school-based response
- what defines a particular event as a crisis
- how will different facets of crisis response be handled (who, what, where)
- how to assess and triage medical and psychological trauma
- how to identify students and staff in need of aftermath intervention
- what types of responses will be made with respect to students, staff, parents, district, community, media
- what special provisions will be implemented to address language and cultural considerations
- which school personnel will make the responses
- how district and community resources will be used
- which personnel will review the adequacy of each response and make appropriate revisions in crises response plans
- what inservice staff development and training are needed.
- how will everyone be informed about emergency and crisis procedures

As part of the general plan, it is essential to address contingencies. What will be done if someone is not at school to carry out their crisis response duties? What if a location is not accessible for carrying on a planned activity?

It should be stressed that school crises often are community crises. Therefore, the school's plan should be coordinated with community crisis response personnel and, where feasible, plans and resources should be seamlessly woven together. The same is true with respect to neighboring schools. A blending of planning and implementation resources assures a wider range of expertise and can increase cost-efficacy.

> As an aid for planning, Resource Aid IIF-2 provides samples of crisis response checklists.

Once a general plan is made, over time planners can work out further details related to specific concerns (see Appendix II-3). In doing so, they should give priority to those that seem to occur with the greatest frequency.

Exhibit 22 presents a matrix outlining the scope of crisis events and phases to be considered in intervention planning. Resource Aid IIF-3 outlines general ideas related to a school-based response to school-wide crises.

> Several points should be highlighted related to Exhibit 22. Clearly, the scope of the event (major school-wide crises as contrasted to small group or individual crises) profoundly shapes how many staff members are needed during the various phases of the crisis.
>
> Also, difficulties that must be dealt with during the crisis itself raise many problems that are quite distinct from those arising in the immediate aftermath and in the days and weeks following the event (e.g., hysteria and fear as contrasted with grief reactions and post traumatic stress).

Exhibit 23 outlines major facets of crisis response related to each of the four phases.

Exhibit 22. Scope of Crisis Events and Intervention Phases

		Scope of Event		
		Major School-wide Crisis (e.g., major earthquake, fire in building, sniper on campus)	Small Group Crisis (e.g., minor tremor, fire in community, suicide)	Individual Crisis (e.g., student confides plan to hurt self/ others)
Phases for which to plan	During the Emergency			
	Immediate Aftermath			
	Days/ Weeks Following			
	Prevention in the Future			

Exhibit 23. Major Facets of Crises Response

During the emergency

- communication (e.g., sounding the alarm if necessary; clarifying additional steps and providing information about the event, location of first aid stations if needed, etc.; rumor control; dealing with the media; keeping track of students and staff; responding to parents; interfacing with rest of the district and community)
- direction and coordination (e.g., running an emergency operations center; monitoring problems; problem solving)
- health and safety (e.g., mitigating hazards to protect students and staff; providing them with medical and psychological first aid; providing for search and rescue, security, evacuation)

Immediate aftermath

- communication (e.g., clarifying causes and impact and debunking rumors; providing information about available resources for medical and psychological help) See Resource Aid IIF-4.
- direction and coordination (e.g., determining need to maintain emergency operations center; continuing to monitor problems and problem solve)
- health and safety (e.g., continuing with activities initiated during the event)

Days/weeks following

- communication (e.g., providing closure to students, staff, parents, district, community)
- direction and coordination (e.g., continuing to monitor problems and problem solve)
- health and safety (e.g., providing for those in need of longer-term treatment either through provision of direct services or referral; case management)

Prevention

- communication (e.g., holding debriefing meetings to clarify deficiencies in response to the crisis)
- direction and coordination (e.g., using debriefing analyses to plan ways to prevent, if feasible, similar events from occurring, to minimize the impact of unavoidable events, to improve crisis response procedures, to enhance resources)
- health and safety (e.g., providing education for students, staff, parents)

A School-Based Crisis Team

Resources are always limited. Some schools will feel that they don't have the resources to devote to a crisis team. The fact is, however, that few schools can afford to risk not being able to respond effectively to crises. Any school that has some team meeting together to address students' problems can at the very least make the focus on crisis part of that team's work. Examples of such teams are a student assistance team, a student study team, or a resource coordinating team. Alternatively, neighboring schools might pool resources to develop a multi-school crisis team.

> As with so many special committees and teams, school-based crisis teams often are initiated with great fanfare but over time simply become a title on a plan. Initial enthusiasm wanes; other activities become more pressing; members leave the school.

To be successful, a school-based crisis team must be highly valued by the school administration and composed of interested staff. The value and interest should be manifested in

- bimonthly crisis team planning/staff development meetings that are scheduled during working hours
- regular communications and staff development activities with the entire school staff
- immediate replacement of departing team members and careful orientation of new members
- formal recognition of team contribution to school's mission, and so forth.

Although some members of a school-based crisis team are dictated by role in the school (e.g., a school administrator, nurse, psychologist), there always are other staff who have special expertise or interest (e.g., SBHC staff with first aid and counseling training).

The following steps are guidelines for establishing, training, and maintaining crisis planning and intervention team(s). The outline in Appendix II-3 offers greater detail regarding these steps.

1. The school's decision makers can identify and empower two staff members who are interested in (motivated to) improve the school's crisis response capability. The SBHC's mental health professional could play an invaluable role as one of the two.

2. These two persons can then proceed to recruit a *core* of about 4-8 others, either by role or because of their special affinity for crisis intervention. This core will do the planning. (In large schools, the core team probably will want additional affiliated team members who can be mobilized when a response is necessary.)

3. Initial training of the team should focus on general crisis intervention policies and practices and on ways to keep the team functioning. It may be necessary to bring in district personnel (or even outside trainers) to provide some of the initial training.

4. After initial training, the team needs to meet regularly (e.g., every few weeks) to formulate and write up specific plans.

5. Plans in hand, a series of inservice meetings for school staff are indicated to increase their awareness of the importance of crisis intervention and the procedures they should follow.

6. After a crisis event, the team should have a special debriefing session to analyze how well procedures were followed and to discuss possible improvements -- including additional training needs and future preventive actions where feasible.

Each team needs to identify a *team leader* to

- organize planning and training sessions
- provide overall coordination during a crisis response
- liaison with district and school administrators and with community emergency response agencies (fire department, police).

Other team members will take on roles and functions related to

- mobilizing the team when needed (e.g., telephone trees, beepers)
- coordinating communications and controlling rumors
- first aid (medical, psychological)
- crowd management
- media
- evacuation and transportation
- individual and group supportive counseling
- aftermath interventions

and so forth.

Every team role and function needs to be backed-up by 1-2 team members in case someone is absent or incapacitated.

In addition to having a designated person and back-ups for mobilizing the team, it is wise to have essential contact information posted in several visible places (e.g., next to phones in office locations).

Obviously, for a team to be effective, it must function well as a group. Thus, it is essential to use planning and training time in ways that build a sense of mutual respect, trust, and support. An effective team communicates well, understands everyone's role, backs each other up, and gets the job done. A member must feel comfortable asking another for assistance during a crisis (especially when feeling overwhelmed). And at the appropriate time, each member indicates appreciation for all that each team member has done.

CRISIS TEAM ACTIVITY: AN EXAMPLE

During the Emergency and in Immediate Aftermath

I. MAJOR SCHOOL-WIDE CRISIS
(e.g., major earthquake, fire in building, sniper on campus)

A. Administration directs and coordinates emergency procedures.
(e.g., emergency procedures such as evacuation, lock-down, contact with hospitals/police, contacts and interfaces with parents in need of direction)

B. Crisis Team members without specific emergency assignments or students-in-hand converge at designated place.

C. Crisis Team sets in motion procedures to
1. gather and disperse accurate information to students, staff, parents, media (special focus on rumor control, support, and debriefing);
2. assess immediate needs for psychological first-aid;
3. ensure sufficient psychological first-aid is in place (e.g., establishes and maintains a special drop-in counseling resource for those affected; supplements resources by calling for district level help);
4. direct students, staff, and parents in need to psychological first-aid resources (announces a central contact place, conducts outreach);
5. keep administration informed.

II. SMALL GROUP CRISIS
(e.g., a situation such as a classmate's death where most students are unaffected; the focus is on providing for *specific* classes, groups, and individuals who are upset)

A. Any member of the Crisis Team who thinks there is a crisis situation can contact another member to decide whether a Team meeting should be called.

B. If they agree, these two members should send a notice convening the meeting at the earliest, feasible time at a designated place.

C. Preset procedures can be followed to cover classes for teachers on the team and to send students back to class who may be having individual appointments with team members.

D. Crisis Team meets to assess who needs psychological support and counseling

E. Crisis Team sets in motion procedures to
1. gather and disperse accurate information to affected students, staff, parents, (special focus on rumor control, support, and debriefing);
2. ensure sufficient support and counseling are in place (e.g., establishes and maintains a special drop-in counseling resource for those affected; supplements resources by calling for district level help);
3. direct students, staff, and parents in need to appropriate resources (announces a central contact place, conducts outreach)
4. coordinate resources and ensure they are maintained as long as needed (who, where)
5. keep administration informed.

(cont.)

III. INDIVIDUAL'S CRISIS

(e.g., student confides threat to hurt self or others such as suicide, assault)

A. Staff, student, or parent may refer such an emergency to any member of the Crisis Team.

B. The Crisis Team member becomes the case manager for the problem until it is resolved or else arranges for someone else to case manage.

C. Preset procedures can be followed to cover classes for teachers on the team and to send students back to class who may be having individual appointments with team members.

D. The case manager is the primary intervener and arranges for appropriate action steps and for a back up crisis team member.

E. The case manager interviews the student and anyone else involved to assess needs
(e.g., degree of danger, resource needs on and off campus, need to contact parents, need to contact legal authorities)

F. Case manager confers with back up team member to set in motion procedures to
1. provide immediate on campus help
2. call for additional support (e.g., from district, county)
3. contact parents

Days/Weeks Following

Following the emergency, the Crisis Team meets to identify appropriate steps for the ensuing days/weeks (e.g., information, support, counseling for classes, groups, individuals)

(1) Circulate accurate information to minimize destructive/disruptive rumors. An example of one procedure for doing this involves providing teachers with accurate information about the event and asking them to judiciously cover the matter with their students. They should be reminded to do this in a way that not only provides accurate information about the event, but clarifies that the feelings students are having are natural and reminds students of available resources should they have a particular concern. Provision should be made to back up teachers (e.g., those who feel their situation requires someone with specific skills). The same type of written notice for parents may also be indicated.

(2) Circulate a handout to all school personnel regarding what they should watch for in the aftermath and what they can do if students appear especially upset.

(3) Implement special support/counseling activities.

Debriefing and Planning for Prevention

At a later date, the Crisis Team meets for a debriefing session to evaluate how procedures worked, what revisions are needed, and to clarify preventive implications.

Crisis Aftermath Subteams

Although all crisis team members are involved in responding to emergencies, special expertise may be required in handling problems that arise in the days and weeks following an event. Thus, it may be worth establishing subteams or designating specific individuals to develop special expertise around the different types of aftermath problems. An aftermath subteam, then, is composed of one or more individuals who are prepared to focus on specific problems (e.g., suicide; violence and gang activity; earthquake, fire, and other natural disasters; rape).

Each subteam draws on the talents of such people as the nurse, school psychologist, counselors, peer counseling coordinators, dropout coordinators, administrators, and any others who have interest and talent related to such problems. To ensure that each subteam and the total team meet regularly for training and other preparedness activity, subteam leaders and a crisis aftermath team coordinator are needed.

It is important to keep in mind that the problems in dealing with the crisis itself are quite distinct from those arising immediately after the circumstances of the event itself are handled. At least, four different types of aftermath problems can be distinguished:

- Disaster reactions
- Grief reactions
- Fear of Violence reactions
- Suicide prevention

Subteams can prepare, implement, and monitor procedures for dealing with the psychosocial *aftermath* of crisis events that are likely to spread to a significant segment of students. Of particular concern are procedures for rumor control, dealing with contagion effects, and providing support for any students who have strong psychological reactions.

(Some persons on the aftermath team also will be on teams designed to deal with the prevention and actual occurrence of crisis events; nevertheless, it is important to distinguish the problems of dealing with the crisis itself from those that arise in the immediate aftermath.)

DEALING WITH THE MEDIA

Media reports can make responding to crises more difficult. Thus, it is essential to have a media coordinator/liaison and to meet with media in a designated area. (Usually, the media should not be given access to students without parent consent.) Everyone should keep the following in mind when dealing with the media.

Prepare

Write down what you want to communicate. In doing so,

- state appropriate concern for victims and their families
- provide appropriate factual information (e.g., students involved, ages), including information about the steps taken to deal with the crisis (as well as any preventive measures previously taken); at the same time, safeguard privacy and confidentiality and details that police should handle related to criminal acts and suicide
- ask media to communicate resources for assistance available at the school and in the community.

You will find it useful to have prepared and kept on file the outline of a formal news release so that you can simply fill in the details prior to meeting with the media.

Give Straightforward Information

No matter what you are told, assume that everything you say will be quoted (and perhaps misquoted). Thus, respond to questions by reiterating points from your prepared statement. However, when you don't have information on a matter, simply state this in a straightforward manner. Keep a positive demeanor.

Avoid Common Mistakes

- Don't restate any question you are asked (especially negatively phrased questions) because through editing and selective quoting it can be made to appear part of your statement.
- Don't interpret events or motives or predict what will happen.
- Don't speculate, ad lib, blame anyone, or try to be deceptive.
- Don't let anyone bate you into an argument because you are almost certain to look like you are defensive (perhaps trying to hide something), and you probably will say something in a way that reflects badly on you and the school.

Correct the Record

As you become aware of errors in media coverage, take the opportunity of future media inquiries to include corrective information in you statement.

Maintaining Crisis Response Capability and School Awareness

Because of changes in staffing and in staff interests, crisis response procedures must be reviewed at the beginning of each school year and may need revitalization. It probably requires 2-3 dedicated staff to keep the process functioning well.

In this regard, a school nurse can play an important catalytic role. For example, at the beginning of a school year, s/he can help arrange an early meeting of crisis response personnel to

- review and improve crisis response procedures
- plan information dissemination to staff and students
- plan additional inservice training for crisis response.

Another aspect of maintaining crisis response capability arises from efforts to maintain staff and student awareness of crisis procedures. That is, if regular steps are taken to keep staff and students informed, this can result in continuous review and improvement procedures.

For multiple reasons, then, it is essential for someone to take responsibility for planning how to keep staff and students aware and updated on the school's crisis response procedures. This task might fall to a school administrator or to a crisis team member.

Examples of steps that might be taken are

1. Each class could be provided with an outline of "Emergency Procedures" and "Crisis Team information" to be posted on the wall.
2. At the beginning of each semester, updated information could be circulated to all school personnel explaining who can be contacted and the function of the Crisis Team.
3. At the beginning of the year and at midyear a presentation could be made at a faculty meeting.
4. As another reminder and update, monthly reports based on the minutes from crisis planning and debriefing meetings also might be reproduced and circulated to all school personnel.

Psychological First Aid

Pynoos and Nader (1988) discuss psychological first aid for use during and in the immediate aftermath of a crisis (providing a detailed outline of steps according to age). Their work helps all of us think about some general points about responding to a student who is emotionally upset.

Psychological first aid for students/staff/parents can be as important as medical aid (See Resource Aid IIF-5 for indicators of reactions to trauma.) The immediate objective is to help individuals deal with the troubling psychological reactions.

(1) Managing the situation. A student who is upset can produce a form of *emotional contagion.*

To counter this, staff must

- present a calm, reassuring demeanor
- clarify for classmates and others that the student is upset
- if possible indicate why (correct rumors and distorted information)
- state what can and will be done to help the student.

(2) Mobilizing support. The student needs *support and guidance.*

Ways in which staff can help are to

- try to engage the student in a problem-solving dialogue
  >normalize the reaction as much as feasible
  >facilitate emotional expression (e.g., through use of empathy, warmth, and genuineness)
  >facilitate cognitive understanding by providing information
  >facilitate personal action by the student
  (e.g., help the individual do something to reduce the emotional upset and minimize threats to competence, self-determination, and relatedness)
- encourage the student's buddies to provide social support
- contact the student's home to discuss what's wrong and what to do
- refer the student to a specific counseling resource (see Resource Aid IIF-6 for a sample crisis screening interview).

Exhibit 24 provides a few general principles related to responding to crises.

Exhibit 24. A Few General Principles Related to Responding to Crises

Immediate Response -- Focused on Restoring Equilibrium

In responding:

- Be calm, direct, informative, authoritative, nurturing, and problem-solving oriented.
- Counter denial, by encouraging students to deal with facts of the event; give accurate information and explanations of what happened and what to expect -- never give unrealistic or false assurances.
- Talk with students about their emotional reactions and encourage them to deal with such reactions as another facet of countering denial and other defenses that interfere with restoring equilibrium.
- Convey a sense hope and positive expectation -- that while crises change things, there are ways to deal with the impact.

Move the Student from Victim to Actor

- Plan with the student promising, realistic, and appropriate actions they will pursue when they leave you.
- Build on coping strategies the student has displayed.
- If feasible, involve the student in assisting with efforts to restore equilibrium.

Connect the Student with Immediate Social Support

- Peer buddies, other staff, family -- to provide immediate support, guidance, and other forms of immediate assistance.

Take Care of the Caretakers

- Be certain that support systems are in place for staff in general
- Be certain that support (debriefing) systems are in place for all crisis response personnel.

Provide for Aftermath Interventions

- Be certain that individuals needing follow-up assistance receive it. (see Resource Aid IIF-7 for examples of classroom activities)

REFLECTIONS ON CRISIS COUNSELING

When I first joined the crisis team, I thought we'd usually be dealing with emergencies that disrupted the whole school. But, most of the emergencies have involved individual students who seem suicidal or have taken a drug overdose, and most of the aftermath counseling has involved small groups of students and staff who are affected by the death of a student or staff member.

In times of crisis, I often have felt overwhelmed by the der[illegible] of despair and grief experienced by so many. In reaching out, I have ha[illegible] learn how to draw in those among the quiet ones who will let some of i[illegible]ut only if I encourage turn-taking during an aftermath group session.

I also have learned how to avoid overwhelming those who are not ready, psychologically, to deal with what happened and those for whom the event itself is not important except as a trigger setting off strong emotions (e.g., pent up grief related to the death of others who were close to them and/or fears about their own mortality). At the same time, I've learned to avoid playing into the dynamics of those who just seem to get caught up in and want to maintain the supercharged atmosphere created by a crisis.

Early in my crisis team experience, I was surprised when one administrator seemed reluctant to have the team offer aftermath support. He wanted things to return to 'normal' as fast as possible and was convinced the team's activity would keep things stirred up. He also expressed concern that many students would be overwhelmed by the added pressures of reflecting on what had happened, listening to others' reactions, and expressing their own. He had concluded that the best strategy was to encourage everyone to put the event behind them and get on with things. We agreed that he was probably right with respect to most students. And, we finally convinced him that we could proceed in ways that would help to normalize the situation for the majority and still provide for those with special needs.

I have since learned that many people share a concern that crisis interveners don't appreciate how many individuals are ready to get on with things. So, I always try to assure everyone that I understand this, and then I clarify that helping those with special needs is an important part of getting things back to normal.

(cont.)

REFLECTIONS ON CRISIS COUNSELING (cont).

A specific aspect of normalization after the death of a student or staff member seems to be a wide-spread desire to gather funds to help the family if there is a need and/or to arrange a tribute. When this is the case, the concerned energy of most of the school population can be channeled in this direction after initial expressions of emotion are validated. Extended aftermath groups are necessary only for those seen as profoundly affected.

One of the hardest things about crisis counseling is establishing a relationship with students who don't know me at a time when they desperately need someone familiar whom they can trust. Therefore, I try, whenever possible, to enlist someone to work beside me who the students look up to. At the very least, I quickly identify someone in the group with whom I can ally myself.

Responding to crisis is exhausting. Thus, we have found it essential to have enough team members to spell each other whenever extended counseling is required on a given day. In responding to the needs of others, it is easy to ignore the impact on ourselves.

As a health professional, what drew me to crisis intervention is that I knew it was an essential element of any comprehensive approach to maintaining psychological well-being. What I didn't realize was what a powerful contribution an active school-based crisis team could make to a school's sense of community. At first, team meetings focused on improving crisis response plans and communicating them to the rest of the school. We found our efforts to take care of these matters were reassuring to others. Once these tasks were accomplished, we found ourselves addressing other school safety concerns and ways for students and staff to be more supportive of each other. In many ways, the crisis team has become a special forum for sharing concerns and a symbol of the school community's commitment to taking care of each other. And, I think that is pretty basic to maintaining our mental health!

Addressing Specific Areas of Concern Related to Crises

Given the range of crises that SBHC staff are called upon to deal with, it is not feasible to cover all the specifics here. As a further resource Appendix II-4 provides some resource aids on the following topics:

- **Community and Gang Violence**
- **Suicidal Crisis**
- **Family Violence**
- **Sexual Assault**
- **Grief and Loss**
- **Hostage Situations**
- **Post Traumatic Stress Disorder**

While it takes a while for all members of a crisis team to learn about such specific areas of concern, each member might elect to focus on a particular topic and then *over time* share what has been learned with others on the team and with the rest of the staff.

RESOURCE AIDS

A. Resource Aids Included Here

Resource Aid IIF-1

District Policy Considerations

Outlines forms of support that districts may provide.

Resource Aid IIF-2

Crisis Response Checklist

This is a checklist of major things to be done related to immediate response and follow-up activity. Also included here is an example of a checklist developed by one large school district.

Resource Aid IIF-3

Some Key Considerations in Establishing a System for School-Based Crisis Response

Outlines nine points answering some basic concerns that arise during discussions of planning school-based crisis response.

Resource Aid IIF-4

Informing the Students and Staff

Provides a few guidelines and an example of how to announce crisis-related information. A sample letter for informing the family is also included here.

Resource Aid IIF-5

A Few Indicators of Reactions to Trauma

A handout for staff to raise their awareness.

Resource Aid IIF-6

A Crisis Screening Interview

A brief instrument to aid in clarifying whether a student needs special assistance in dealing with reactions to a crisis.

Resource Aid IIF-7

Aftermath Classroom Activities

Handouts for pre-school and kindergarten, elementary, and junior and senior high.

B. Related Resource Aid Packets Available from Our Center

Responding to Crisis at a School

Provides a set of guides and handouts for use in crisis planning and as aids for training staff to respond effectively. Contains materials to guide the organization and initial training of a school-based crisis team, as well as materials for use in ongoing training and as information handouts for staff, students, and parents.

Violence Prevention and Safe Schools

Outlines selected violence prevention curricula and school programs and school-community partnerships for safe schools. Emphasizes both policy and practice.

DISTRICT POLICY CONSIDERATIONS

Check to see if the district has made a policy statement about crisis intervention or any specific form of crisis related event, such as a natural disaster, an act of violence in the schools, or the death of a student or staff member. Such statements should help clarify how the district defines a crisis, how it has designed its overall response to crises, and what type of responses it expects at each school. The statement also may suggest specific organization and strategies for crisis response. It also may indicate the district's position on seeking help from individuals and agencies not affiliated with the district (other than public sector emergency services).

The following is a brief indication of the type of specific guidelines you may find in district policy statements.

From a district's perspective, crises usually are events that have the potential to

- cause a major disruption in normal functioning
- produce major physical and/or psychological harm to those at the school (e.g., students, staff, parents).

The definition may be limited to events that affect the entire population at a school, or it may be extended to events that affect subgroups or even an individual (e.g., in the case of a potential suicide). Regardless of the breadth of definition, the first concern of policy makers is for ensuring physical safety; hopefully, this is followed immediately by attention to psychological considerations.

Ideally, district policy specifies guidelines for district and school-by-school planning, organizing, and training for crises, and debriefing after a crisis (with a view to improving future crises responses and preventive actions). In particular, guidelines can help answer such questions as

- How do we decide that a situation should be treated as a crisis?
- How do we decide what responses are needed to deal with the crisis?
- How do we ensure that planned responses are implemented?
- How do we enlist additional help?

Districts will differ in the specificity with which they spell out procedures for a school to follow during a crisis. Optimally, the district not only will detail such procedures, but also will provide for district level support. District level support is useful in establishing and maintaining crisis response mechanisms and in training and consulting with on-site staff, as well as providing for supplemental staffing to respond to specified crises. In large districts, such support may be organized regionally (e.g., regional support crisis teams consisting of representatives of medical and psychological/ counseling support services, district administration, media relations).

In some districts, a school-based crisis intervention team is delineated as the prototype mechanism to provide for the physical safety and psychological needs of students, staff, and parents in responding to a crisis. Such a team also might be assigned responsibility for on-site planning for crises response, or else some of the members might participate on a crisis planning team. Because situations vary, district policy probably will not specify team membership or size other than to cite the need for participation by role (e.g., administrator, nurse, psychologist, counselor, teachers). Obviously, ultimate responsibility for the team belongs to the principal; however, the principal probably will be expected to delegate such responsibility -- perhaps to the team as a whole.

Resource Aid IIF-2

Crisis Response Checklist

In the midst of a crisis, it is hard to remember all the specific steps and preparatory plans that have been discussed. Each site and each person responsible for crisis response needs to have a checklist that provides a ready and visible reference guide for use during a crisis. Such a checklist is also an important training tool. The following is an outline of what such a checklist might cover.

I. Immediate Response

Check to be certain that

____ appropriate "alarms" have been sounded

____ all persons with a crisis role are mobilized and informed as to who is coordinating the response and where the coordination/emergency operation center and medical and psychological first aid centers are located

This may include coordinators for
- ____ overall crisis response
- ____ first aid (medical, psychological)
- ____ media
- ____ communications
- ____ crowd management
- ____ transportation

____ phone trees are activated

____ team leader and others clarify whether additional resources should be called in (from the District or community -- such as additional medical and psychological assistance, police, fire)

____ all assignments are being carried out (including provisions for classroom coverage for crisis response team members and for any instances of a staff death)

____ corrective steps are being taken when the response is inadequate

____ all communication needs are addressed by implementing planned means for information sharing and rumor control (e.g. Public Address announcements, circulation of written statements, presentations to staff/students/ parents in classes or in special assemblies);

This includes communications with
- ____ staff
- ____ students
- ____ crisis team
- ____ media
- ____ home
- ____ district offices and other schools
- ____ community
- ____ fire, police

____ plans for locating individuals are implemented (e.g., message center, sign-in and sign-out lists for staff and students)

____ specific intervention and referral activity are implemented (e.g., triage, first-aid, search, rescue, security, evacuation, counseling, distribution of information about resources and referral processes -- including teentalk and suicide prevention lines and interviews to assess need for individual counseling)

____ support and time out breaks for crisis workers are implemented

____ informal debriefings of crisis workers are done to assess how things are going and what will be required in the way of follow-up activity.

II. Follow-up Activity

In the **aftermath**, check to be certain that

____ continuing communication needs are addressed (clarifying causes and impact, debunking rumors, updating facts, providing closure; updating information on available resources)

____ if relevant, family contacts are made to learn funeral and memorial service arrangements, and to determine if there is additional assistance the school can provide (School-related memorial services for gang members, suicides, etc. are controversial; clear policies should be established in discussing crisis response plans.)

____ crisis-related problems continue to be monitored and dealt with (including case management of referrals and extended treatment)

____ facets of crisis response that are no longer needed are brought to an appropriate conclusion

____ debriefing meetings are held (to appreciate all who helped, clarify deficiencies in crisis response, and make revisions for the next time)

____ crisis response plans are revised and resources enhanced for dealing with the next crisis

____ additional training is planned and implemented

____ appropriate prevention planning is incorporated (e.g., at least to minimize the impact of such events)

Example of One District's *Crisis Checklist*

I. ASSESSMENT

___A. Identify problem and determine degree of impact on school.

___B. Take steps to secure the safety and security of the site as needed.
(see Emergency Disasters Procedures Manual, Sept. 1994)

___C. Make incident report to district administrator.

___D. Determine if additional support is needed.
  ___1. Call school police and/or city police
  ___2. Call Cluster Crisis Team
  ___3. Call other district crisis personnel

___E. Alter daily/weekly schedule as needed.

II. INTERVENTION: COMMUNICATION

___A. Set up a Command Center

___B. Establish Sign-In Procedures at ALL campus entry sites*

___C. Administrator/designee/crisis manager should:
  ___1. Review facts/determine what information should be shared
  ___2. Consider police investigation parameters
  ___3. Notify family with sensitivity and dispatch. (Consider a personal contact with family.)

___D. Develop and disseminate bilingual FACT SHEET (written bulletin)
  ___1. Faculty
  ___2. Students
  ___3. Parents/Community

___E. Begin media interactions.
  ___1. Identify a media spokesperson (Office of Communications may be utilized)
  ___2. Designate a location for media representatives.*

___F. Contact neighboring schools

___G. Contact schools of affected students siblings.

___H. Other communication activities
  ___1. Classroom presentations/discussions
  ___2. Parent/community meetings
  ___3. School staff meeting

___I. Provide for RUMOR CONTROL
  ___1. Keep a TV set or radio tuned to a news station
  ___2. Verify ALL facts heard
  ___3. Update Fact Sheet as needed
  ___4. Utilize student leaders:
    a) As sources knowledgeable of rumors among students
    b) As peer leaders to convey factual information
    c) As runners (written bulletins should be sealed when necessary)

III. INTERVENTION: FIRST AID AND EMERGENCY RELEASE PLAN

___A. Initiate First Aid Team procedures

___B. Designate Emergency Health Office location*

___C. Initiate Emergency Release Plan procedures

___D. Designate student check-out location*

IV. INTERVENTION: PSYCHOLOGICAL FIRST AID/COUNSELING

___A. Logistics: Designate rooms/locations/areas**
  ___1. Individual counseling -- Location: ______________________________**
  ___2. Group counseling -- Location: ______________________________**
  ___3. Parents -- Location: ______________________________**
  ___4. Staff (certificated and classified) -- Location: ____________________**
  ___5. Sign-In for Support Services -- Location: ____________________

___B. Initiate the referral process, including procedures for self-referral.
  ___1. Identify a crisis team member to staff all locations.**
  ___2. Provide bilingual services as needed.
  ___3. Distribute appropriate forms for student counseling referrals to staff.
  ___4. Disseminate student referral information to teachers and other staff.

___C. Identify and contact high risk students.

___D. Identify and contact other affected students, staff, and personnel.

___E. Initiate appropriate interventions:
- Individual counseling
- Group counseling
- Parent/community meetings
- Staff meetings (ALL staff)
- Classroom activities, presentations
- Referrals to community agencies

IV. INTERVENTION: DISSEMINATE APPROPRIATE HANDOUTS TO STAFF/PARENTS

V. INTERVENTION: DEBRIEFING

___A. Daily and mandatory

___B. Crisis intervention activities
  ___1. Review the actions of the day
  ___2. Identify weaknesses and strengths of crisis interventions
  ___3. Review status of referred students
  ___4. Prioritize needs/personnel needed the next day
  ___5. Plan follow-up actions

___C. Allow time for emotional debriefing

* Logistics/room designations/space allocations
** Support personnel needed for these locations

Developed by the Los Angeles Unified School District

Some Key Considerations in Establishing a System for School-Based Crisis Response

The following nine points provide answers to some basic concerns that arise during discussions of school-based crisis response.

(1) Scope of events

All schools require a clear set of emergency procedures for dealing with major, school-wide crises (e.g., earthquake, fire, snipers) when they occur and in the immediate aftermath.

Decisions have to be made about whether the scope of crisis response will include specified procedures for any of the following:

- crises that affect smaller segments of the student body
- crises experienced by individual students (e.g., drug overdose, suicide attempt)
- community events that produce strong reactions among students at school (e.g., earthquakes that occur during nonschool hours, a neighborhood shooting of a gang member who is student)
- planning responses (e.g., psychological support) for helping (treating/referring) traumatized students (staff?) in the days and weeks following an event
- preventive procedures

(2) Crisis criteria

When should an event be seen as requiring a crisis response?

With the exception of most major, school wide crises, crises tend to be in the eye of the beholder. Thus, some school personnel are quite liberal and others are quite conservative in labeling events as crises.

After deciding on the scope of events to be treated as crisis, the dilemma of the planners and ultimately of the decision makers is that of establishing a set of checks and balances to ensure potential crises are not ignored *and* that there is not an overreaction to events that should not be treated as crises. Given the inevitability of differences regarding how an event is perceived, efforts to formulate crisis criteria probably should focus on delineating an expedient *process* for deciding rather than the more difficult task of detailing what is and isn't a crisis.

For example, one school developed a process whereby each member of its crisis team was encouraged to take the initiative of contacting another team member whenever s/he felt an event might warrant a crisis response. If the contacted team member agreed that the event should be seen as a crisis, the rest of the crisis team were contacted immediately for a quick meeting and vote. If the majority concurred, the event was defined as a crisis and appropriate crisis responses were implemented.

(3) Who needs aftermath help?

Again, there will be inevitable differences in perception. It is clear, however, that plans must be in place to provide help and/or referral whenever staff, parents, or students themselves indicate that a student is experiencing significant emotional reactions to a crisis. Usually, all that is needed is a procedure for alerting everyone to the possibility of emotional reactions and who on the staff will be providing support and counseling and/or referrals.

Planners also may want to consider what types of general responses may be appropriate with regard to specific types of events. Should there be a "debriefing" meeting for the entire school? for specific subgroups?

And decisions will have to be made about whether there will be support/counseling/referrals for emotional reactions of school staff.

(4) Types of responses

Planning focuses on delineating, establishing, and maintaining procedures and equipment and assigning responsibilities for (1) communication, (2) direction and coordination, and (3) health and safety during each of the four phases specified in the accompanying Figure. It encompasses every major detail related to who, what, where, when, and how.

Other materials in this unit provide examples of the types of activities to be considered in such planning.

A special need arises with respect to handling the media. It has become increasingly evident that each school should identify and train a specific person to act as a spokesperson in order to minimize the ways media reports can exacerbate difficult situations.

(5) Providing for Language and Cultural Differences

The influx of immigrants has increased the necessity of identifying individuals who speak the language and are aware of relevant cultural considerations that may arise during a crisis response. If one is fortunate enough to have such individuals on the school staff (in professional or nonprofessional positions), then planning involves delineating their roles during the crisis, clarifying how they can be freed from other responsibilities, and how they can be trained to carry out their special roles. If such persons are not readily available, then planning also must address how to recruit such help. Possible sources include mature students, parents, staff from nearby community agencies, other community volunteers.

Scope of Crisis Events and Intervention Phases

Phases for which to plan	*Scope of Event* Major School-wide Crisis (e.g., major earthquake, fire in building, sniper on campus)	Small Group Crisis (e.g., minor tremor, fire in community, suicide)	Individual Crisis (e.g., student confides plan to hurt self/ others)
During the Emergency			
Immediate Aftermath			
Days/ Weeks Following			
Prevention in the Future			

(6) Which School Staff Respond to Crises

Obviously, there are some staff who because of their role are critical to the success of crisis response (e.g., school nurses, psychologists, specific administrators, office staff, plant manager). In addition, there are others who have relevant interests and special abilities (e.g., first aid and counseling skills). To provide a comprehensive and coordinated response, plans should focus on ways to establish, train, and maintain a Crisis Intervention Team consisting of a combination of both types of staff (i.e., role-relevant and interested individuals). In all likelihood, there will be considerable overlap between the Crisis Planning Committee and the Crisis Intervention Team. Plans also must be made to identify, train, and maintain a number of individuals who will play supplementary roles when there are major disasters such as fires, earthquakes, and large-scale violence on campus (e.g., all school personnel, designated students, parent liaisons).

(7) Other District and Community Resources

Some crises require mobilization of off-campus resources. Planning involves identifying available resources and clarifying steps by which they will be mobilized when needed.

(8) Crisis Debriefing

At an appropriate time after a crisis response, an analysis of the quality of the response should be made to identify the need for improved procedures and additional training. For this to occur, a planning committee must designate who will organize the debriefing and who will be responsible for following through with developing improved procedures and organizing training sessions.

(9) Inservice Training

In addition to training needs that emerge from debriefing analyses, plans should be made for ongoing staff development based on requests from staff involved in crisis planning and intervention.

Informing the Students and Staff

Many administrators prefer not to make a P.A. announcement when there has been a crisis event that affects the school. There is no hard and fast rule here. In part, it depends on the situation (such as how much there is a need for immediate communication), and in part it depends on the ability of the administrator to use the P.A. in an effective manner.

Thus, the most common means of communication is a note to teachers and school staff members. Such communications should be made as quickly as feasible and should be done in a clear and open manner (providing all known information). In turn, teachers and staff are directed to inform students, doing so with concern and caring so as to calm and clarify. If feasible, students should be informed in small-group settings where questions can be answered, rumors clarified, and concerns addressed.

The following is a sample of a statement used to provide staff and students with relevant information about the death of a student.

> We regret to inform you of the death of (name). S/he died on (date) as a result of
>
> At times such as these, it is important for everyone to be informed and to have some time to express thoughts and feelings. Part of first period will be used for such sharing.
>
> In addition, we encourage anyone who is very upset to come to room ( ) where staff members will be available throughout today to help. Staff members will also be available upon request over the next two days should anyone want further assistance. Such assistance can be obtained by (explain process).
>
> As soon as the information is available, we will circulate a notice about funeral arrangements and provisions for attending if the funeral is during school hours.

Facilitating Class Discussion

In general, informing and discussing a traumatic event with students is best done in small-groups where questions can be answered, rumors clarified, and concerns addressed. Some students may choose not to enter into discussion, and some may even express a desire to be excused. Don't force the situation; honor the student's wishes.

Students often start off by saying such things as

I feel terrible.

S/he was my friend.

Why did it have to happen?

I'm really mad that it happened.

We knew he was upset; we should have done something.

Things like this don't make sense.

It could happen to me.

It's just one of those things.

I can't believe it.

If it weren't for (name of someone), it wouldn't have happened.

You can often help keep students more fully express their thoughts and feelings by paraphrasing what they have just said. Try not to make intrusive comments. At the same time, move the discussion away from any attempts to glamorize or romanticize the event.

After they have been able to express themselves, you need to let them know that what they are thinking and feeling is very natural under the circumstances and that, for some of them, it may take a while before such thoughts and feelings are worked through.

Be sure to tell them that who is available to students if they or a friend are very upset. Watch for any student who appears very upset and follow predetermined procedures for connecting that student with someone who is ready to provide psychological first aid.

Sample Letter to Send Home

November 20, 1996

Dear Family Members:

We regret to inform about an unfortunate event affecting our school. Yesterday, (brief factual statement about event). An investigation is underway, and until it is complete we will not have all the details about this tragedy.

The school's crisis team has begun meeting with students and staff. We anticipate some may need continuing support for a while to help them deal with the emotional upset that such an event produces. In this regard, enclosed are some materials that you may find helpful in talking about the matter at home.

If you have any questions or concerns you think we can help address, please feel free to call the school (number) and ask for any of the following staff:

____.

The following community agencies also are ready to help anyone who is feeling overwhelmed by their emotions.

(local) Community Mental Health Center (phone)
Family Services (phone)
etc.

We know that events such as this are stressful. We are taking every step we can to be responsive to the needs of our students and their families.

Sincerely,

Principal

A Few Indicators of Reactions to Trauma

No one should be overzealous in seeing normal variations in student's development and behavior as problems. At the same time, school professionals don't want to ignore indicators of significant problems. The following are meant only to sensitize responsible professionals. They should not be seen as a check list.

> If a student is of significant concern, a request should be made to an appropriate person on the school staff who can do some further screening/assessment.

If they occur frequently and in a variety of situations and appear rather serious when you compare the behavior with other students the same age, the following behaviors may be symptomatic of significant problems.

Emotional appearance

(Emotions seem excessive. Displays little affect. Very rapid shifts in emotional state.)

very unhappy, sad, teary, depressed, indicates a sense of worthlessness, hopelessness, helplessness

excessive anger or self-blame (especially if it is expressed as threats to harm self or others

very afraid, fearful

can't seem to control emotions

doesn't seem to have feelings

Personal Actions

(Acts in ways that are troublesome or troubling)

- frequent outbursts, violent
- cruel to others
- sleep problems and/or nightmares
- wetting/soiling at school
- agitated and easily distracted
- destroys things
- accident prone
- excessive/uncontrolled talking
- often doesn't seem to hear
- hurts self, self-abusive
- truancy, school avoidance
- trouble learning and performing
- eating problems
- ritualistic behavior
- isolates self from others
- unaccounted for weight loss
- substance abuse
- runs away

(cont.)

Interactions with others

(Doesn't seem interested in others. Can't interact appropriately or effectively with others.)

doesn't pay attention

cruel and bullying

highly manipulative

alienates others

has no friends

refuses to talk

promiscuous

excessively reactive and resistant to authority

highly aggressive to others -- physically, sexually

Indicators of Unusual Thinking

(Has difficulty concentrating. May express very strange thoughts and ideas.)

worries a lot

doesn't stay focused on matters

can't seem to concentrate on much

seems disoriented, has trouble knowing what day it is or relating recent events

may indicate fear s/he is losing her/his mind

is preoccupied with some idea (often bizarre) or with death

seems to hear or see things, delusional, may experience flashbacks

denies apparent problems

A Crisis Screening Interview

Interviewer________________________ Date__________

Note identified problem:

Is the student seeking help? Yes No

If not, what were the circumstances that brought the student to the interview?

Student's Name ________________________________ Age _____ Birthdate ___________

Sex: M F Grade ________ Current class ______________________

Ethnicity __________________ Primary Language ____________________

We are concerned about how things are going for you. Our talk today will help us to discuss what's going O.K. and what's not going so well. If you want me to keep what we talk about secret, I will do so -- except for those things that I need to discuss with others in order to help you.

In answering, please provide as much details as you can. At times, I will ask you to tell me a bit more about your thoughts and feelings.

1. Where were you when the event occurred?
   (Directly at the site? nearby? out of the area?)

2. What did you see or hear about what happened?

3. How are you feeling now?

4. How well do you know those who were involved?

5. Has anything like this happened to you or any of your family before?

6. How do you think this will affect you in the days to come?
(How will your life be different now?)

7. How do you think this will affect your family in the days to come?

8. What bothers you the most about what happened?

9. Do you think anyone could have done something to prevent it? Yes No
Who?

10. Thinking back on what happened,	not at all	a little	more than a little	very
how angry do you feel about it?	1	2	3	4
how sad do you feel about it?	1	2	3	4
how guilty do you feel about it?	1	2	3	4
how scared do you feel?	1	2	3	4

11. What changes have there been in your life or routine because of what happened?

12. What new problems have you experienced since the event?

13. What is your most pressing problem currently?

14. Do you think someone should be punished for what happened? Yes No
Who?

15. Is this a matter of getting even or seeking revenge? Yes No
Who should do the punishing?

16. What other information do you want regarding what happened?

17. Do you think it would help you to talk to someone about how you feel about what happened?

Yes No Who? How soon?

Is this something we should talk about now? Yes No What is it?

18. What do you usually do when you need help with a personal problem?

19. Which friends and who at home can you talk to about this?

20. What are you going to do when you leave school today?
If you are uncertain, let's talk about what you should do?

Aftermath Classroom Activities

In addition to discussion, teachers can help students deal with their reactions to a crisis through a variety of classroom activities.

The work done on this by the Los Angeles Unified School District has been found useful by schools around the country. For example, Genesee County in Michigan has included the following adaptation in their crisis handbook.

Classroom activities enable students to express and discuss feelings about crises. The following are simply examples to stimulate teachers' planning.

PRE-SCHOOL AND KINDERGARTEN ACTIVITIES

Play Reenactment

Toys that encourage play reenactment of students' experiences and observations during a traumatic experience can help integrate the experiences. Useful toys include fire trucks, rescue trucks, dump trucks, ambulances, building blocks and dolls.

Physical Contact

Children need lots of physical contact during times of stress to regain a sense of security. Games involving structured physical touching help meet this need.

Nourishment

Extra amounts of finger foods and fluids help provide the emotional and physical nourishment children need in times of stress. Oral satisfaction is especially necessary, because children tend to revert to more regressive or primitive behavior in response to feelings that their survival or security is threatened.

Puppets

Playing with puppets can be effective in reducing inhibitions and encouraging children to discuss their feelings.

Art

Have the children do a mural on butcher paper with topics such as what happened when the traumatic event occurred. This is recommended for small groups with discussion afterward, directed by an adult. Have the children draw individual pictures about the event and then discuss or act out elements of their pictures. This activity allows for discussing experiences, and helps children discover that others share their fears.

Stories

Read stories to the children that tell about other children's (or animals') experiences in a disastrous event. This can be a nonthreatening way to convey common reactions to frightening experiences, and to stimulate discussion. It helps to emphasize how people resolve feelings of fear.

Large Muscle Activity

When children are restless or anxious, any activities that involve large muscle movements are helpful. You might try your own simple version of doing exercises to music, like skipping and jumping.

ELEMENTARY SCHOOL ACTIVITIES

Play Reenactment

For younger children, using toys that encourage play reenactment of their experience and observations during the traumatic event can help integrate the traumatic experience. Toys might include ambulances, dump trucks, fire trucks, building blocks and dolls.

Puppets

Play with puppets can be effective in reducing inhibitions and encouraging children to talk about their feelings and thoughts. Children often will respond more freely to a puppet asking about what happened than to an adult asking the questions directly. Help or encourage students to develop skits or puppet shows about what happened in the event. Encourage them to include anything positive about the experience as well as those aspects that were frightening or disconcerting.

Art and Discussion Groups

Do a group mural on butcher paper with topics such as "What happened in your neighborhood (school name or home) when the traumatic event occurred?" This is recommended for small groups with discussion afterward, facilitated by an adult. This type of activity can help students feel less isolated with their fears and provide the opportunity to vent feelings. Have the children draw individual pictures and then talk about them in small groups. It is important in the group discussion to end on a positive note (such as a feeling of mastery or preparedness, noting that the community or family pulled together to deal with the crisis:), in addition to providing the opportunity to talk about their feelings about what took place.

Share Your Own Experience

Stimulate group discussion about disaster experiences by sharing your own feelings, fears or experiences. It is important to legitimize feelings to help students feel less isolated.

Disaster Plans

Have the children brainstorm their own classroom or family disaster plan. What would they do if they had to evacuate? How would they contact parents? How should the family be prepared? How could they help the family?

Reading

Read aloud, or have the children read, stories or books that talk about children or families dealing with stressful situations, pulling together during times of hardship, and similar themes.

(cont.)

Creative Writing or Discussion Topics

In a discussion or writing assignment, have the children describe in detail a very scary intense moment in time and a very happy moment. Create a group story, recorded by the teacher, about a dog or cat that was in an earthquake, flood or other disaster. What happened to him? What did he do? How did he feel? You can help the students by providing connective elements. Emphasize creative problem-solving and positive resolution.

Playacting

In small groups, play the game, "If you were an animal, what would you be?" You might adapt discussion questions such as "If you were that animal, what would you do when some traumatic event occurred?" Have the children take turns acting out an emotion in front of the class, without talking, and have the rest of the class guess what the feeling is and why the student might have that feeling. Do this for good as well as bad feelings.

Other Disasters

Have the children bring in newspaper clippings on disasters that have happened in other parts of the world. Ask the students how they imagine the survivors might have felt or what they might have experienced.

Tension Breakers

A good tension breaker when students are restless is the co-listening exercise. Have the children quickly pair up with a partner. Child #1 takes a turn at talking about anything he or she wants to, while Child #2 simply listens. After three minutes, they switch roles and Child #2 talks while Child #1 listens.

Also, when the children are anxious and restless, any activities that involve large muscle movements are helpful. You might try doing your own version of exercises to music, like skipping or jumping.

JUNIOR HIGH AND HIGH SCHOOL

Activities

Classroom activities that relate the traumatic event to course study can be a good way to help students integrate their experiences and observations, while providing specific learning experiences. In implementing the following suggestions, or ideas of your own, it is important to allow time for the students to discuss feelings stimulated by the projects or issues being covered.

Home Room Class

Group discussion of their experiences of the event is particularly Important among adolescents. They need the opportunity to express feelings, as well as to normalize the extreme emotions they may have experienced. A good way to stimulate such a discussion is for the teacher to share his or her own reactions to the event. The students may need considerable reassurance that even extreme emotions and crazy thoughts are normal in a traumatic event. It is important to end such discussions on a positive note, such as talking about what heroic acts were observed.

Break the class into small groups and have them develop a disaster plan for their home, school or community. This can help students regain a sense of mastery and security, as well as having practical merit. The small groups can then share their plans in a discussion with the entire class.

Conduct a class discussion and/or support a class project on how the students might help the community recovery effort. It's important to help them develop concrete and realistic ways they might be of assistance. Community involvement can help overcome feelings of helplessness and frustration, and deal with survivors guilt and other common reactions in disaster situations.

Have a home safety or preparedness quiz. What would you do under certain circumstances (such as finding a hurt child, being without water or electricity, or having an earthquake hit the area). Talk about what is necessary to survive in the wilderness. How does this knowledge apply to a community following a disaster? Encourage students who have had first aid training to demonstrate basic techniques to the class.

Science

Conduct projects on stress, physiological response to stress, and how to deal with it.

Creative Writing

Ask the students to write about an intense moment they remember very clearly not a day or an hour, but a short period of time lasting no more than three minutes. Make up a funny disaster. Write a story about a person who is in a disaster and give it a happy ending.

(cont.)

Literature or Reading

Have the students read a story or novel about young people or families who have experienced hardship or disaster. Have a follow-up discussion on how they might react if they were the character in the story.

Psychology Class

Initiate a discussion on how course content might apply to the stress reactions students observed during and following a traumatic event. Discuss post-traumatic stress syndrome. Have a guest speaker from Mental Health Services or a therapist involved in counseling victims speak to the class.

Peer Listening

Provide information on common responses to traumatic events. Use structured exercises using skills students are learning in class to help them integrate their experiences. Point out that victims need to repeat their stories many times. Students can help family and friends affected by the event by using good listening skills.

Health Class

Discuss emotional reactions to the event and the importance of taking care of one's own emotional well being. Discuss health hazards in a disaster, such as water contamination or food that may have gone bad due to lack of refrigeration. Discuss health precautions and safety measure. Guest speakers from public health and/or mental health and from the fire department might talk to the class.

Art Class

Have the students portray their experiences or observations of the event in various art media. Have the students do a group project, such as a mural, showing the community recovery efforts following a disaster.

Speech/Drama

Have the students portray the catastrophic emotions that come up in response to a traumatic event. Have the students develop a skit about some aspect of the event.

Math Class

Have the class solve mathematical problems related to the impact of the event.

Social Studies/Government

Study governmental agencies responsible for aid to victims. How do they work? How effective are they? Write letters or petitions to agencies responsible for handling disasters. Discuss the political implications of the event within a community.

History Class

Discuss historical events and disasters. Discuss how the victims and survivors of those events might have felt. Have the students bring in newspaper clippings on current events in other parts of the world. What kinds of experiences might the victims have had?, Have you experienced anything similar?

A Few Related References

Bloom, B.L. (1984). Crisis intervention. In B.L. Bloom, *Community mental health.* Monterey, CA: Brooks/Cole.

Burke, J.D., Jr., Borus, J.F., Burnes, B., Millstein, K.H., & Beasley, M.D. (1982). Changes in children's behavior after a natural disaster. *American Journal of Psychiatry, 139,* 1010-1014.

Eth, S., & Pynoos, R. (Eds.). (1985). *Post-traumatic stress disorder in children.* Washington, DC: American Psychiatric Press.

Frederick, C. (1985). Children traumatized by catastrophic situations. In J. Laube & S.A. Murphy (Eds.), *Perspectives on disaster recovery.* Norwalk, CN: Appleton-Century-Crofts.

Galante, R., & Foa, D. (1986). An epidemiological study of psychic trauma and treatment effectiveness for children after a natural disaster. *Journal of the American Academy of Child Psychiatry, 25,* 357-363.

Gilliland, B.E. & James, R.K. (1993). *Crisis intervention strategies* (2nd ed.). Pacific Grove, CA: Brooks/Cole.

Hudson, J. (1989). Principals should devise an action plan before tragedy strikes. *Nation's Schools Report, 15,* 1-4.

Jay, B. (1989). Managing a crisis in the school -- Tips for principals. *NASSP Bulletin,* 15-18.

Kelly, D.G., Stimeling, W.F., & Kachur, D.S. (1989). Before worst comes to worst, have your crisis plan ready. *The Executive Educator,* 22-23.

Poland, S. & Pitcher, G. (1990). Best practices in crisis intervention. In A. Thomas & J. Grimes (Eds.), *Best practices in school psychology--II.* Washington, DC: National Association of School Psychologists.

Pynoos, R.S., & Nader, K. (1988). Psychological first aid and treatment approach to children exposed to community violence: Research implications. *Journal of Traumatic Stress, 1,* 445-473.

Schonfeld, D.J., Kline, M., & Members of the Crisis Intervention Committee (1994). School-based crisis intervention: An organizational model. *Crisis Intervention, 1,* 155-166.

Utterback, J., & Caldwell, J. (1989). Proactive and reactive approaches to PTSD in the aftermath of campus violence: Forming a traumatic stress react team. *Journal of Traumatic Stress, 2,* 171-183.

UNIT IIG: MANAGEMENT OF CARE & FOLLOW-UP EVALUATION (CASE MANAGEMENT)

Contents *Page*

- Initial Monitoring of Care IIG-2
- Ongoing Monitoring/Management of Care IIG-3

Resource Aids IIG-7

  IIG-1 Follow-Up Rating Form -- Service Status IIG-8
  IIG-2 Management of Care Review Form IIG-10

A Few References on the Basics of Helping and Counseling IIG-18

UNIT IIG
Management of Care & Follow-Up Evaluation

Early in a center's development, the emphasis is on regular monitoring and formative evaluation to ensure students' needs are met. In subsequent phases of center development, longer-term case follow-up and efficacy evaluation.

Specific tasks involved here include

- Immediate monitoring through feedback from interveners, students, and records

- Continued monitoring and formative evaluation through feedback from interveners, students, and records

As already suggested, case management begins from the time a student is referred. Monitoring forms sent to students and interveners provide an easy way to check on the appropriateness of a current service.

Immediate Monitoring. As already noted, a student follow-through interview can be done within the first few weeks after projected enrollment in a service (see referral follow-up forms included as Resource Aids in Unit IID and Resource Aids IIG-1 and 2). This is a good time for identifying students who did not follow-through (perhaps because of a practical problem not identified and worked on during screening).

Continued Monitoring/Management and Formative Evaluation. Follow-up checks are indicated periodically. At the very least, a student follow-up interview seems indicated after 2 months and/or at the date a service originally was scheduled to end. If the findings indicate the student did not successfully enroll or stay in a program or is not doing well, another consultation session can be scheduled to reassess the student's needs and to determine whether another referral should be made determine or other next steps. If the intervention is completed, the focus shifts to an evaluation of status at end of intervention (see Resource Aid IIG-1 and 2).

317

Managing Care, Not Cases

"To take care of them"
can and should be read
with two meanings:
to give children help
and to exclude them
from the community.
Nicholas Hobbs

Embedded within the meaning of care that emphasizes help also is caring. Many professionals have suggested that a sense of caring is crucial if programs and services are to be successful in helping youngsters. Thus, in discussing management of care, they assume the intent is to help and the method should convey a sense of caring. To avoid undermining the emphasis on care, the word "case" (as in case management) can be replaced with the term *care*.

> Whatever term is used, the process involves (1) initial monitoring, (2) ongoing management of an individual's prescribed assistance, and (3) system's management.

As with any intervention, these activities must be implemented in ways that are developmentally and motivationally appropriate, as well as culturally sensitive.

Initial Monitoring of Care

Stated simply, monitoring of care is the process by which it is determined whether a client is appropriately involved in prescribed programs and services. Initial monitoring by school staff focuses on whether a student/family has connected with a referral resource.

> As already indicated, all monitoring of care requires systems that are designed to gather information about follow-through and that the referral resource is indeed turning out to be an appropriate way for to meet client needs (see Resource Aids in Unit IID and at the end of this unit).

When a client is involved with more than one intervener, management of care becomes a concern. This clearly is always the situation when a student is referred for help over and above that which her/his teacher(s) can provide.

Subsequent monitoring as part of
the ongoing management of client care
focuses on coordinating interventions,
improving quality of care
(including revising intervention
plans as appropriate),
and enhancing cost-efficacy.

Ongoing Monitoring/Management of Care

Remember that from the time a student is first identified as having a problem, someone should be monitoring/managing the case. The process encompasses a constant focus to evaluate the appropriateness and effectiveness of the various efforts. That is, monitoring is the process of checking regularly to ensure that a student's needs are being met so that appropriate steps can be taken if they are not. Such monitoring continues until the student's intervention needs are addressed. It takes the form of management of care when there must be coordination among the efforts of others who are involved (e.g., other interventions including the efforts of the classroom teacher and those at home).

Monitoring involves follow-ups with interveners and students/ families. This can take a variety of formats (e.g., written communications, phone conversations, electronic communications). More specifically, such ongoing monitoring requires systems for

- *tracking client involvement in interventions*
- *amassing and analyzing data on intervention planning and implementation*
- *amassing and analyzing progress data*
- *recommending changes*

All monitoring and management of care require a system of record keeping designed to maintain an up-to-date record on the status of the student as of the last contact and that reminds you when a contact should be made. (Again, see the various Resource Aids designed to facilitate follow-up on referrals and ongoing monitoring/managing of care.)

> Management of care, of course, involves more than monitoring processes and outcomes. Management also calls for the ability to produce changes as necessary.

Sometimes steps must be taken to improve the quality of processes, including at times enhancing coordination among several interveners. Sometimes intervention plans need to be revised to increase their efficacy and minimize their "costs" -- including addressing negative "side effects." Thus, management of care involves using the findings from ongoing monitoring to clarify if interventions need to be altered and then implements strategies to identify appropriate changes and ensure they are implemented with continued monitoring. Along the way, those involved in managing the client's care may have to advocate for and broker essential help and provide the linkage among services that ensures they are coordinated. They also must enhance coordinated intervener communication with the student's caregivers at home.

> Who does all this monitoring and management of care? Ideally, all involved parties -- interveners and clients -- assume these functions and become the *management team.* One member of such a team needs to take *primary* responsibility for management of care (a *primary manager*). Sites with sufficient resources often opt to employ one staff member to fill this role for all clients. However, given the limited resources available to schools, a more practical model is train many staff to share such a role. Ultimately, with proper instruction, one or more family members might be able to assume this role.

All who assume the role or primary care manager must approach it in a way that respects the client and conveys a sense of caring. The process should be oriented to problem-solving but should not be limited to problem treatments (e.g., in working on their problems, young people should not be cut off from developmental and enrichment opportunities). In most instances, a youngster's family will be integrally involved and empowered as partners, as well as recipients of care.

Unfortunately, there are times when a client is forced to enroll and/or remain in a program (e.g., mandated counseling, diversion programming). By definition, such intervention eliminates client choice and self-determination and is likely to be experienced as disempowering. Clients in such situations can be expected to manifest various forms of reactive behavior. The challenge for all interveners in these instances is one of overcoming negative motivation by finding ways the client can regain their sense of self-determination. The primary care manager can assist in meeting this need by inviting the client's participation in all subsequent team reviews and decision making.

Well-implemented management of care can help ensure that clients are helped in a comprehensive, integrated manner that addresses her/him as a whole person. A positive side effect of all this can be enhancement of systems of care.

> Management teams need to meet whenever analysis of monitoring information suggests a need for program changes or at designated review periods. Between meetings, it is the responsibility of the primary manager to ensure care is appropriately monitored and team meetings are called whenever changes are needed. It is the team as a whole, however, that has responsibility for designating necessary changes and working to ensure designated changes are made.

A few basic guidelines for primary managers of care are

- write up analyses of monitoring findings and recommendations to share with management team;

- immediately after a team meeting, write up and circulate changes proposed by management team and emphasize who has agreed to do which tasks by when (see Resource Aids);

- set-up a "tickler" system (e.g., a notation on a calendar) to remind you when to check on whether tasks have been accomplished;

- follow-up with team members who have not accomplished agreed upon tasks to see what assistance they need.

Advanced Technology to Assist with Student Care

School sites with health or family service centers already have entered the age of computer assistance in providing care for students and their families. Constantly evolving systems are available not only to facilitate record keeping and reporting, but to aid with assessment and consultation, referrals, program planning, and ongoing management of care. As schools and other agencies move to computerized information systems, the capacity for integration and networking will be greatly enhanced.

For example, schools and community agencies will have the opportunity to share relevant information in ways that protect client privacy and enhance collaborative intervention. The advanced technology will also allow for rapid updating of information about available services, and school staff will be able to help students/families sign-up on-line. Computer technology also can be used as another modality to enhance counseling and therapy.

Beyond enhancing efforts to treat problems, the advanced technology opens up new avenues for students and parents to seek out information for themselves and connect with others for support.

Of course, as with any tool, computer software varies in quality and can be misused. For instance, reliance on computer programs to generate diagnoses will predictably exacerbate current trends to overuse psychopathological diagnoses in identifying mild-to-moderate emotional, learning, and behavior problems.

Similarly, there is a danger that schools will develop their computerized information and computer-assisted intervention systems in a fragmented and piecemeal manner. This will result in a waste of scarce resources and will reduce the usefulness of what is potentially an extremely powerful aid in efforts to address barriers to student learning and enhance healthy development.

References

Marzke, C. (1995). *Information systems to support comprehensive, integrated service delivery and sustainability*. Sacramento, CA: Walter MacDonald & Associates (916) 427-1410.

Thornburg, D. (1991). *Education, technology, and paradigm changes for the 21st century*. Starsong Pub.

RESOURCE AIDS

A. Resource Aids Included Here

Resource Aid IIG-1

Follow-up Rating Form -- Service Status

Examples of rating forms (one for client self-report; another for he intervener) to provide an indication of how well the intervention is proceeding.

Resource Aid IIG-2

Management of Care Review Form

This form is designed to both guide and provide a record of client care -- including all team activity and decisions.

B. Related Resource Aid Packets Available from Our Center

School-Based Client Consultation, Referral, and Management of Care

Discusses why it is important to approach student clients as consumers and to think in terms of managing *care*, not *cases*. Outlines processes related to problem identification, triage, assessment and client consultation, referral, and management of care. Provides discussion of prereferral intervention and referral as a multifaceted intervention. Clarifies the nature of ongoing management of care and the necessity of establishing mechanisms to enhance systems of care. Examples of tools to aid in all these processes are included.

Confidentiality and Informed Consent

Focuses on issues related to confidentiality and consent of minors in human services and interagency collaborations. Also includes sample consent forms.

Cultural Concerns in Addressing Barriers to Learning

Highlights concepts, issues and implications of multiculturalism/cultural competence in the delivery of educational and mental health services, as well as for staff development and system change. This packet also includes resource aids on how to better address cultural and racial diversity in serving children and adolescents.

Follow-up Rating Form -- Service Status **(Intervener Form)**

(To be filled out periodically by ***interveners)***

To: (Intervener's name)

From: ______________________, Primary Care Manager

Re: Current Status of a client referred to you by _________________ school.

Student's Name or ID # _________________________ Birthdate _______ Date___________

Number of sessions seen: Ind.___ Group ____

What problems were worked on?

Current status of problems worked on: (Severity at this time)

1	2	3	4
very severe	severe	not too severe	not at all severe

If the problems worked on differ from the "presenting" problems (e.g., referral problem), also indicate the current status of the presenting problems.

1	2	3	4
very severe	severe	not too severe	not at all severe

Recommendations made for further action:

Are the recommendations being followed? YES NO
If no, why not?

How much did the intervention help the student in better understanding his/her problems?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	quite a bit	very much

How much did the intervention help the student to deal with her/his problems in a better way?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	quite a bit	very much

Prognosis

1	2	3	4
very positive	positive	negative	very negative

Follow-up Rating Form -- Service Status (Client Form)

(To be filled out periodically by the clients)

Student's Name or ID # ______________________ Birthdate ______ Date __________

1. How worthwhile do you feel it was for you to have worked with the counselor?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	quite a bit	very much

2. How much did the counseling help you better understand your problems?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	quite a bit	very much

3. How much did the counseling help you deal with your problems in a better way?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	quite a bit	very much

4. At this time, how serious are the problems for you?

1	2	3	4
very severe	severe	not too severe	not at all severe

5. How hopeful are you about solving your problems?

1	2	3	4
very hopeful	somewhat hopeful	not too hopeful	not at all hopeful

If not hopeful, why not?

6. If you need help in the future, how likely are you to contact the counselor?

1	2	3	4
not at all	not too likely	likely to	definitely will

Management of Care Review Form

Student's Name or ID # ______________________ Birthdate ______

Primary Manager of Care ____________________________________

Management of Care Team (including student/family members):

__________________ __________________ __________________

__________________ __________________ __________________

Initial Plan

Date management of care file opened: __________

Student Lives with: ______________________ Relationship ______________

Address ____________________________ Phone ______________

Home language ____

Type of concern initially presented
(briefly describe for each applicable area)

How serious are the problems?

	not too serious					**very serious**
Learning:	1	2	3	4	5	6
Behavior:	1	2	3	4	5	6
Emotional:	1	2	3	4	5	6
Other:	1	2	3	4	5	6

Problem Identified and Referred by: ____________________ date ________

Initial client consultation done with: ____________________ date ________
Conducted by: ____________________

Indicate diagnosis (if any): ____________________

Recommendations/Decisions/consents:

Planned Date for Immediate Follow-up: __________
(2 weeks after recommended action)

Immediate Follow-up Date: ____________________

Appropriate client follow-through? Yes No

If no, why not?

Is the original plan still appropriate? Yes No

If no, why not?

What changes are needed?

Any problems with coordination of interventions? Yes No

If yes:

What needs to be done?	By Who?	When?	Monitoring Date:

If plan has changed, indicate new recommendations/decisions (including plans for improving coordination):

SYSTEMS OF CARE REVIEW: Any general implications for improving the school's systems for referral, triage, client consultation, management of care, integration of school programs, and work with other agencies? If so, these implications should be directed to those responsible for enhancing the system.

Planned date for first team review: ______________________
(in about 2 months or sooner if necessary)

The primary manager must be certain that (1) everyone understands revised plans and needs to improve coordination and (2) appropriate steps are taken to facilitate action. This requires monitoring activity in the days and weeks that follow this follow-up check.

First Team Review Date: ________________

Team members present:

____________________ ____________________

____

____________________ ____________________

____

General Update on Client Status (indicate source of information, progress, ongoing concerns, etc.)

With respect to concerns initially presented, at this time --

Amount of Improvement Seen

	not too much					**very much**
Learning:	1	2	3	4	5	6
Behavior:	1	2	3	4	5	6
Emotional:	1	2	3	4	5	6
Other:	1	2	3	4	5	6

Appropriate client follow-through? Yes No

If no, why not?

Is the current plan still appropriate? Yes No

If no, why not?

What changes are needed?

Any problems with coordination of interventions? Yes No

If yes:

What needs to be done? By Who? When? Monitoring Date:

If plan has changed, indicate new recommendations/decisions (including plans for improving coordination):

SYSTEMS OF CARE REVIEW: Any general implications for improving the school's systems for referral, triage, client consultation, management of care, integration of school programs, and work with other agencies? If so, these implications should be directed to those responsible for enhancing the system.

Planned date for next team review: ____________________
(in about 2 months or sooner if necessary)

The primary manager must be certain that (1) everyone understands revised plans and needs to improve coordination and (2) appropriate steps are taken to facilitate action. This requires monitoring activity in the days and weeks that follow this follow-up check.

Note: This sheet may be used several times over the course of intervention (e.g., every 2 mths)

Ongoing Team Review Date: ____________

Team members present:

____________ ____________ ____________

____________ ____________ ____________

General Update on Client Status (indicate source of information, progress, ongoing concerns, etc.)

With respect to concerns initially presented, at this time --

	How Severe?					
	not too severe					**very severe**
Learning:	1	2	3	4	5	6
Behavior:	1	2	3	4	5	6
Emotional:	1	2	3	4	5	6
Other:	1	2	3	4	5	6

Appropriate client follow-through? Yes No

If no, why not?

Is the current plan still appropriate? Yes No

If no, why not?

What changes are needed?

Any problems with coordination of interventions? Yes No

If yes:

What needs to be done?	By Who?	When?	Monitoring Date:

If plan has changed, indicate new recommendations/decisions (including plans for improving coordination):

SYSTEMS OF CARE REVIEW: Any general implications for improving the school's systems for referral, triage, client consultation, management of care, integration of school programs, and work with other agencies? If so, these implications should be directed to those responsible for enhancing the system.

Planned date for next team review: ____________________
(in about 2 months or sooner if necessary)

The primary manager must be certain that (1) everyone understands revised plans and needs to improve coordination and (2) appropriate steps are taken to facilitate action. This requires monitoring activity in the days and weeks that follow this follow-up check.

End of Intervention Date: ____________

Final Update on Client Status (indicate source of information, progress, ongoing concerns, etc.)

With respect to concerns initially presented,
at this time --

How Severe?

	not too severe					**very severe**
Learning:	1	2	3	4	5	6
Behavior:	1	2	3	4	5	6
Emotional:	1	2	3	4	5	6
Other:	1	2	3	4	5	6

Why is the intervention ending?

If the client still needs assistance, what are the ongoing needs?

What plans are there for meeting these needs?

If there are no plans, why not?

SYSTEMS OF CARE REVIEW: Any general implications for improving the school's systems for referral, triage, client consultation, management of care, integration of school programs, and work with other agencies? If so, these implications should be directed to those responsible for enhancing the system.

With intervention ending, the primary manager must be certain that (1) everyone who should be informed is provided relevant information and (2) evaluation data are entered into the appropriate systems.

A Few References on the Basics of Helping and Counseling

Basch, M. (1995). *Doing brief psychotherapy.* New york: Basic Books.

Brown, D.T. & Prout, H.T. (Eds.) (1989). *Counseling and psychotherapy with children and adolescents: Theory and practice for school and clinic settings* (2nd ed.). Brandon, VT: CPPC.

Hames, C.C. & Joseph, D.H. (1986). *Basic concepts of helping: A holistic approach.* Norwalk, CT: Appleton-Century-Crofts.

Lauver, P. & Harvey, D.R. (1997). *The practical counselor: Elements of effective helping.* Pacific Grove, CA: Brooks/Cole.

Martin, D.G. & Moore, A.D. (1995). *First steps in the art of intervention: A guidebook for trainee in the helping professions.* Pacific Grove, CA: Brooks/Cole.

Meier, S.T. & Davis, S.R. (1997). *The elements of counseling* (3rd ed.) Pacific Grove, CA: Brooks/Cole.

Okun, B.F. (1997). *Effective helping: Interviewing and counseling techniques* (5th ed.). Pacific Grove, CA: Brooks/Cole.

Orton, G.L. (1997). *Strategies for counseling with children and their parents.* Pacific Grove, CA: Brooks/Cole.

Appendix II-1

Connecting a Student with the Right Help

Connecting a Student with the Right Help

As highlighted in throughout Unit II, the process of connecting the student with appropriate help can be viewed as encompassing four facets: (1) screening/assessment, (2) client consultation and referral, (3) triage, and (4) monitoring/managing care. This appendix provides a bit more information about such matters.

Screening to Clarify Need

Most of the time it will not be immediately evident what the source of a student's problems are or how severe or pervasive they are. As you know, the causes of behavior, learning, and emotional problems are hard to analyze. What looks like a learning disability or an attentional problem may be emotionally-based; behavior problems and hyperactivity often arise in reaction to learning difficulties; problems with schooling may be due to problems at home, reactions to traumatic events, substance abuse, and so forth. It is especially hard to know the underlying cause of a problem at school when a student is unmotivated to learn and perform.

> This, then, becomes the focus of initial assessment -- which essentially is a screening process. Such screening can be used to clarify and validate the nature, extent, and severity of a problem. It also can determine the student's motivation for working on the problem. If the problem involves significant others, such as family members, this also can be explored to determine the need for and feasibility of parental and family counseling.

In pursuing screening/assessment and diagnosis, the following points should be considered:

- When someone raises concerns about a student with you, one of the best tools you can have is a structured referral form for them to fill out. This encourages the referrer to provide you with some detailed information about the nature and scope of the problem. An example of such a form is provided at the end of this section.
- To expand your analysis of the problem, you will want to gather other available information. It is good practice to gather information from several sources -- including the student. Useful sources are teachers, administrators, parents, sometimes peers, etc. If feasible and appropriate, a classroom observation and a home visit also may be of use. You will find some helpful tools in the accompanying materials.
- And you can do a screening interview. The nature of this interview will vary depending on the age of the student and whether concerns raised are general ones about misbehavior and poor school performance or specific concerns about lack of attention, overactivity, major learning problems, significant emotional problems such as appearing depressed and possibly suicidal, or about physical, sexual, or substance abuse. To balance the picture, it is important to look for assets as well as weaknesses. (In this regard, because some students are reluctant to talk about their problems, it is useful to think about the matter of talking with and listening to students -- see Exhibit 20).
- In doing all this, you will want to try to clarify the role of environmental factors in contributing to the student's problems.

Screening: A Note of Caution

Formal screening to identify students who have problems or who are "at risk" is accomplished through individual or group procedures. Most such procedures are *first-level* screens and are expected to *over identify* problems. That is, they identify many students who do not really have significant problems (false positive errors). This certainly is the case for screens used with infants and primary grade children, but false positives are not uncommon when adolescents are screened. Errors are supposed to be detected by follow-up assessments.

> Because of the frequency of false positive errors, serious concerns arise when screening data are used to diagnose students and prescribe remediation and special treatment. Screening data primarily are meant to sensitize responsible professionals. No one wants to ignore indicators of significant problems. At the same time, there is a need to guard against tendencies to see *normal variations* in student's development and behavior as problems.

Screens do not allow for definitive statements about a student's problems and need. At best, most screening procedures provide a preliminary indication that something may be wrong. In considering formal diagnosis and prescriptions for how to correct the problem, one needs data from assessment procedures that have greater validity.

> It is essential to remember that many factors that are symptoms of problems also are common characteristics of young people, especially in adolescence. Cultural differences also can be misinterpreted as symptoms. To avoid misidentification that can inappropriately stigmatize a youngster, all screeners must take care not to overestimate the significance of a few indicators and must be sensitive to developmental, cultural, and other common individual differences.

BEST COPY AVAILABLE

Remember:

- Students often somaticize stress; and, of course, some behavioral and emotional symptoms stem from physical problems.
- Just because the student is having problems doesn't mean that the student has a pathological disorder.
- The student may just be a bit immature or exhibiting behavior that is fairly common at a particular development stage. Moreover, age, severity, pervasiveness, and chronicity are important considerations in diagnosis of mental health and psychosocial problems. The following are a few examples to underscore these points.

Age	*Common Transient Problem*	*Low Frequency Serious Disorder*
0-3	Concern about monsters under the bed	Sleep Behavior Disorder
3-5	Anxious about separating from parent	Separation Anxiety Disorder (crying & clinging)
5-8	Shy and anxious with peers (sometimes with somatic complaints)	Reactive Attachment Disorder
	Disobedient, temper outbursts	Conduct Disorder Oppositional Defiant Disorder
	Very active and doesn't follow directions	Attention Deficit-Hyperactivity Disorder
	Has trouble learning at school	Learning Disabilities
8-12	Low self-esteem	Depression
12-15	Defiant/reactive	Oppositional Defiant Disorder
	Worries a lot	Depression
15-18	Experimental substance use	Substance Abuse

- The source of the problem may be stressors in the classroom, home, and/or neighborhood. (Has the student's environment been seriously looked at as the possible culprit?)
- At this stage, assessment is really a *screening* process such as you do when you use an eye chart to screen for potential vision problems. If the screening suggests the need, the next step is referral to someone who can do indepth assessment to determine whether the problem is diagnosable for special education and perhaps as a mental disorder. To be of value, such an assessment should lead to some form of prescribed treatment, either at the school or in the community. In many cases, ongoing support will be indicated, and hopefully the school can play a meaningful role in this regard.

Client Consultation and Referral

When someone becomes concerned about a student's problems, one of the most important roles to play is assisting the individual in connecting directly with someone who can help. This involves more than referring the student or parents to a resource. The process is one of turning referral procedures into an effective intervention in and of itself.

> Minimally, such an intervention encompasses consultation with the concerned parties, assisting them by detailing the steps involved in connecting with potential referral resources, and following-up to be certain of follow-through. It may also include cultivating referral resources so that you can maximize their responsiveness to your referrals.

Using all the information you have gathered, it is time to sit down with those concerned (student, family, other school staff) and explore what seems to be wrong and what to do about it.

Such consultation sessions are part of a shared problem solving process during which you provide support by assisting the involved parties in

- analyzing the problem (Are environmental factors a concern? Are there concerns about underlying disorders?)
- laying out alternatives (clarifying options/what's available)
- deciding on a course of action (evaluating costs vs. benefits of various alternatives for meeting needs)

Finally, it is essential to work out a sound plan for ensuring there is follow-through on decisions.

Because some facets of client consultation and referral may be new to you, a few more comments may be helpful here.

> Referrals are relatively easy to make; *appropriate* referrals are harder; and *ensuring follow-through* is the most difficult thing of all. Appropriate referrals are made through a consultation process that is consumer oriented and user friendly. They also are designed as a transition-type intervention; that is, recognizing that many students/families are reluctant to follow-through on a referral, they include procedures that support follow-through.

A consumer oriented system is designed with full appreciation of the nature and scope of student problems as perceived by students, their families, and their teachers. Such problems range from minor ones that can be dealt with by providing direct information, perhaps accompanied by some instruction to severe/pervasive/chronic conditions that require intensive intervention.

The process must not ignore the social bases of a student's problems. This means attending to environmental concerns such as basic housing and daily survival needs, family and peer relations, and school experiences. A student's needs may range from accessing adequate clothes to acquiring protection from the harassment of gang members. In many instances, the need is not for a referral but for mobilizing the school staff to address how they might improve its programs to expand students' opportunities in ways that increase expectations about a positive future and thereby counter prevailing student frustration, unhappiness, apathy, and hopelessness.

A consumer oriented system should minimally

- provide readily accessible basic information about relevant resources
- help students/families appreciate the need for and value of a potential resource
- account for problems of access (e.g., cost, location, language and cultural sensitivity)
- aid students/families in reviewing their options and making decisions in their own best interests
- provide sufficient support and guidance to enable students/families to connect with a referral resource
- follow-up with students/families (and referrers) to determine whether referral decisions were appropriate.

Thinking in terms of intervention steps, a good consultation and referral process helps you do the following:

(1) *Provide ways for students/families and school personnel to learn about existing resources*

This entails widespread circulation of general information about on- and off-campus programs and services and ways to readily access such resources.

(2) *Establish whether a referral is necessary*

This requires an analysis of whether current resources can be modified to address the need.

(3) *Identify potential referral options with the student/family*

Review with the student/family how referral options can assist. A resource file and handouts can be developed to aid in identifying and providing information about appropriate services and programs -- on and off-campus -- for specific types of concerns (e.g., individual/group/family/professional or peer counseling for psychological, drug and alcohol problems, hospitalization for suicide prevention). Remember that many students benefit from group counseling. And, if a student's problems are based mainly in the home, one or both parents may need counseling -- with or without the student's involvement as appropriate. Of course, if the parents won't pursue counseling for themselves, the student may need help to cope with and minimize the impact of the negative home situation. Examples of materials that can provide students, families, and staff with ready references to key resources are provided by the accompanying Resource Aids.

(4) *Analyze options with student/family and help with decision-making as to which are the most appropriate resources*

This involves evaluating the pros and cons of potential options (including location, fees, least restrictive and intrusive intervention needed) and, if more than one option emerges as promising, rank ordering them. For example, because students often are reluctant to follow-through with off-campus referrals, first consideration may be given to those on-campus, then to off-campus district programs, and finally to those offered by community agencies. Off-campus referrals are made with due recognition of school district policies.

(5) *Identify and explore with the student/family all factors that might be potential barriers to pursuing the most appropriate option*

Is there a financial problem? a transportation problem? a problem about parental consent? too much anxiety/fear/apathy? At this point, it is wise to be certain that the student (and where appropriate the family) truly feels an intervention will be a good way to meet her or his needs.

(6) *Work on strategies for dealing with barriers to follow-through*

This often overlooked step is essential to follow-through. It entails taking the time to clarify specific ways to deal with apparent barriers.

(7) *Send the student/family off with a written summary of what was decided including follow-through strategies*

A referral decision form can summarize (a) specific directions about enrolling in the first choice resource, (b) how to deal with problems that might interfere with successful enrollment, and (c) what to do if the first choice doesn't work out. A copy of a referral decision form can be given to the student/family as a reminder of descions made; tehoriginal can be kept on file for purposes of case monitoring. Before a student leaves, it is essential to evaluate the likelihood of follow-through. (Does s/he have a sound plan for how to get from here to there?) If the likelihood is low, the above tasks bear repeating.

(8) *Also send them off with a follow-through status report form*

Such a form is intended to let the school know whether the referral worked out, and if not, whether additional help is called for in connecting the student/family to needed resources. Also, remember that teachers and other school staff who asked you to see a student will want to know that something was done. Without violating any confidentiality considerations, you can and should send them a quick response reassuring them that the process is proceeding.

(9) *Follow-through with student/family and other concerned parties to determine current status of needs and whether previous decision were appropriate*

This requires establishing a reminder (tickler) system so that a follow-up is made after an appropriate period of time.

Obviously, the above steps may require more than one session with a student/family and may have to be repeated if there is a problem with follow-through. In many cases, one must take specific steps to help with follow through, such as making direct connections (e.g., by phone) to the intake coordinator for a program. Extreme cases may require extreme measures such as arranging for transportation or for someone to actually go along to facilitate enrollment.

> It is wise to do an immediate check on follow-through (e.g., within 1-2 weeks) to see if the student did connect with the referral. If the student hasn't, the contact can be used to find out what needs to be done next.

Increasingly, as a way to minimize the flood of referrals from teachers, what are called *prereferral interventions* are being stressed. These represent efforts to help students whose problems are not too severe by improving how teachers, peers, and families provide support. A particular emphasis in enhancing prereferral efforts is on providing staff support and consultation to help teachers and other staff learn new ways to work with students who manifest "garden variety" behavior, learning, and emotional problems. Over time, such a staff development emphasis can evolve into broader stakeholder development, in which all certificated and classified staff, family members, volunteers, and peer helpers are taught additional strategies for working with those who manifest problems.

Triage

Problems that are mild to moderate often can be addressed through participation in programs that do not require special referral for admission. Examples are regular curriculum programs designed to foster positive mental health and socio-emotional functioning; social, recreational, and other enrichment activities; and self-help and mutual support programs. Because anyone can apply directly, such interventions can be described as *open-enrollment* programs.

Given there are never enough resources to serve those with severe problems, it is inevitable that the processing of such students will involve a form of triage (or gatekeeping) at some point.

When referrals are made to on-site resources, it falls to the school to decide which cases need immediate attention and which can be put on a waiting list. Working alone or on a team, school nurses can play a key role in making this determination.

Referrals are easy to make . . .

unfortunately, data suggest that follow-through rates for referrals made by staff at school sites are under 50%.

An old fable tells of an arthritic Bulgarian peasant and her encounter with a doctor. After an extensive examination, he diagnoses her problem and writes a prescription for medication, details a special diet, and recommends that she have hydrotherapy. The doctor's professional manner and his expert diagnosis and prescription naturally filled the woman with awe, and as she leaves his office, she is overcome with admiration and says the Bulgarian equivalent of "Gee, you're wonderful doctor!"

A few years pass before the doctor runs into the woman again. As soon as she sees him, she rushes up, and kisses his hand and thanks him again for his marvelous help. The doctor, of course, is gratified. Indeed, he is so pleased that he fails to notice that she is as crippled as before.

The fact is that the woman never got the medication because she neither had the money nor access to an apothecary. Moreover, her village had no provision for hydrotherapy, and the prescribed diet included too many foods that she either did not like or could not afford.

Nevertheless, despite her continuing pain, she remained full of awe for the wise doctor and praised him to everyone who would listen.

(Adapted from Berne, 1964)

Monitoring/Managing Care

As indicated, it is wise to do an immediate check on follow-through (e.g., within 1-2 weeks) to see if the student did connect with the referral. Besides checking with the student/family, it is also a good idea to get a report on follow-through from those to whom referrals are made.

If there has been no follow-through, the contact can be used to clarify next steps. If there has been follow-through, the contact can be used to evaluate whether the resource is meeting the need. The opportunity also can be used to determine if there is a need for communication and coordination with others who are involved with the student's welfare. This is the essence of *case management* which encompasses a constant focus to evaluate the appropriateness and effectiveness of the interventions.

> Follow-up checks are indicated periodically. If the findings indicate the student did not successfully enroll or stay in a program or is not doing well, another consultation session can be scheduled to determine next steps.

Remember that from the time a student is first identified as having a problem, there is a need for someone to monitor/manage the case. Monitoring continues until the student's service needs are addressed. Monitoring takes the form of case management to ensure coordination with the efforts of others who are involved (e.g., other services and programs including the efforts of the classroom teacher and those at home). The process encompasses a constant focus to evaluate the appropriateness and effectiveness of the various efforts.

Systems of Care

The concept of a "system of care" is an evolving idea that is applied in a variety of ways. While management of care is focused on a given client, the concept of systems of care emphasizes the importance of coordinating, integrating, and enhancing systems and resources to ensure that appropriate programs are available, accessible, and adaptable to the needs of the many clients who need help. Moreover, the aim is to ensure these resources are used effectively and efficiently.

> A focus on system resources requires attending to various arenas and levels of potential support. A school has many programs and services that it owns and operates. A school district has additional resources. The surrounding community usually has public and private sector programs and a variety of other resources that may be of assistance. City, county, and state agencies also play a role in addressing certain needs.

In its initial application, the concept of systems of care focused on services to address clients with severe and well-established problems (e.g., youngsters with serious emotional disturbance). The intent of systems of care for such populations is to

- develop and provide a full array of community-based programs (including residential and non-residential alternatives to traditional inpatient and outpatient programs) to enhance what is available and reduce overreliance on out-of-home placements and overly restrictive treatment environments;

- increase interagency collaboration in planning, developing, and carrying out programs to enhance efficacy and reduce costly redundancy;

- establish ways that interventions can be effectively adapted to the individuals served.

To expand these goals to encompass prevention, there are increasing calls for incorporating primary and secondary prevention programs into all systems of care.

At school sites, one mechanism for focusing on enhancing systems of care is a Resource Coordinating Team. Such a team is designed to bring together representatives from all major programs and services addressing barriers to learning and promoting healthy development (e.g., pupils services personnel, a site administrator, special education staff, bilingual coordinators, health educators, noncredentialed staff, parents, older students). It also includes representatives from community agencies that are significantly involved at a school.

> A Resource Coordinating Team differs from teams created to review individual students (such as a student study team) because it focuses on managing and enhancing *systems* to coordinate, integrate, and strengthen interventions. At the same time, many of the same staff usually are on both types of teams. Thus, initial creation of a Resource Coordinating Team often is best accomplished by broadening the scope of a student study team (or a teacher assistance team or a school crisis team). In doing so, however, it is essential to separate the agenda and have the members change "hats."

A Resource Coordinating Team works toward weaving together all school and community programs and services. Among its activities, the team

- conducts resource mapping and analysis with a view to improving resource use and coordination
- ensures that effective systems are in place for triage, referral, management of care, and quality improvement
- establishes appropriate procedures for effective program management and for communication among school staff and with the home
- suggests ways to reallocate and enhance resources (e.g., clarifying how to better use staff and resources, which activities need revision or are not worth continuing).

Properly constituted, trained, and supported, a Resource Coordinating Team can complement the work of the school's governance body through providing on-site overview, leadership, and advocacy for activities aimed at addressing barriers to learning and enhancing healthy development. To these ends, at least one team member should be designated as a liaison between the team and the school's governing and planning bodies to ensure the maintenance, improvement, and increased integration of essential programs and services with the total school program.

> Because they often deal with the same families (e.g., families with children at each level of schooling) and link with the same community resources, complexes of schools (a high school and its feeder middle and elementary schools) should work collaboratively. A Complex Resource Coordinating *Council* brings together representatives from each school's Resource Coordinating Team to facilitate coordination and equity among schools in using school and community resources.

Appendix II-2

ABOUT THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS
(DSM-IV, 1994)

Because the DSM is so widely used throughout the U.S., school professionals need to have some level of awareness of its focus and the categories that are used with respect to children and adolescents. If you are unfamiliar with this classification scheme, you will find a summary description on the following pages.

About the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, 1994)

Among the purposes of diagnostic systems such as the DSM are to (1) facilitate communication among professionals and (2) standardize criteria for diagnosis.

Multiaxial Assessment

With the intent of capturing a good deal of the complexity of psychological problems, the DSM focuses simultaneously on several dimensions. This effort is referred to as multiaxial assessment. Simply stated, an axis is a dimension to be considered in assessment. Recent versions of the Diagnostic and Statistical Manual of Mental Disorders developed by the American Psychiatric Association (see DSM-IV, 1994) include a focus on five dimensions -- thus the term multiaxial. The five are:

Axis I	*Clinical Disorders* -- the focus is on assessing symptoms to identify whether criteria are met for assigning one of the psychiatric disorders (or other conditions that may be the focus of clinical attention) identified in the DSM-IV classification scheme.
Axis II	Personality Disorders/Mental Retardation -- the focus is on facets of an individual's persona or intellectual ability that are likely to be resistant to change.
Axis III	*General Medical Conditions* -- the focus is on any medical conditions that may be contributing to psychological problems or may be a factor in intervention.
Axis IV	*Psychosocial and Environmental Problems* -- the focus is on specific contextual factors that have relevance for conclusions about differential diagnosis, treatment, and prognosis
Axis V	*Global Assessment of Functioning* -- the focus is on how well the individual is presently functioning.

For the four axes (I-IV) that focus on specific areas, the DSM-IV classification scheme provides a range of possible categories and delineates relevant criteria. The categories are:

Axis I

- Disorders usually first diagnosed in infancy, childhood, or adolescence (excluding Mental Retardation, which is diagnosed on Axis II)
- Delirium, dementia, and amnestic and other cognitive disorders
- Mental disorders due to a general medical condition
- Substance-related disorders
- Schizophrenia and other psychotic disorders
- Mood disorders
- Anxiety disorders
- Somatoform disorders
- Factitious disorders
- Dissociative disorders
- Sexual and gender identity disorders
- Eating disorders
- Sleep disorders
- Impulse-control disorders not elsewhere classified
- Adjustment disorders
- Other conditions that may be a focus of clinical attention

Axis II

- Paranoid personality disorders
- Schizoid personality disorders
- Schizotypal personality disorders
- Antisocial personality disorders
- Borderline personality disorders
- Histrionic personality disorders
- Narcissistic personality disorders
- Avoidant personality disorders
- Dependent personality disorders
- Obsessive-compulsive personality disorders
- Personality disorder not otherwise specified
- Mental retardation

Axis III

- Infectious and parasitic diseases
- Neoplasms
- Endocrine, nutritional, and metabolic diseases and immunity disorders
- Diseases of the blood and blood-forming organs
- Diseases of the nervous system and sense organs
- Diseases of the circulatory system
- Diseases of the respiratory system
- Diseases of the digestive system
- Diseases of the genitourinary system
- Complications of pregnancy, childbirth, and the puerperium
- Diseases of the skin and subcutaneous tissue
- Diseases of the musculoskeletal system and connective tissue
- Congenital anomalies
- Certain conditions originating in the perinatal period
- Symptoms, signs, and ill-defined conditions
- Injury and poisoning

Axis IV

- Problems with primary support group
- Problems related to the social environment
- Educational problems
- Occupational problems
- Housing problems
- Economic problems
- Problems with access to health care services
- Problems related to interaction with the legal system/crime
- Other psychosocial and environmental problems

With respect to Axis V (Global Assessment of Functioning), the point is to clarify the level of coping ability/adaptive functioning. The assessor rates the individual on a scale of 1 to 100.

91-100 = superior functioning, no symptoms
81-90 = good functioning, minimal symptoms
71-80 = a few transient and commonplace symptoms
61-70 = mild symptoms but functioning pretty well
51-60 = moderate symptoms and functional problems
41-50 = serious symptoms and impairment in functioning
31-40 = some impairment in reality testing or major impairment in several functional areas
21-30 = delusions or hallucinations or serious impairment in judgment or inability to function
11-20 = some danger of hurting self or others or occasional failure to maintain hygiene
1-10 = persistent danger of severely hurting self or others or inability to maintain hygiene

Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence

The following group of categories is of particular interest to those working with young people.

- Mental Retardation (coded on Axis II)[1]
  - mild mental retardation
  - moderate mental retardation
  - severe mental retardation
  - profound mental retardation
  - mental retardation, severity unspecified
- Learning Disorders[1]
  - reading disorder
  - mathematics disorder
  - disorder of written expression
  - learning disorder NOS[2]
- Motor Skills Disorder
  - development coordination disorder
- Communication Disorders
  - expressive language disorder
  - mixed receptive-expressive language disorder
  - phonological disorder
  - stuttering
  - communication disorder NOS
- Pervasive Developmental Disorders
  - autistic disorder
  - Rett's disorder
  - childhood disintegrative disorder
  - Asperger's disorder
  - pervasive developmental disorder NOS
- Attention-Deficit and Disruptive Behavior Disorders
  - attention-deficit/hyperactivity disorder
    - combined type
    - predominantly inattentive type
    - hyperactive-impulsive type
  - attention-deficit hyperactivity disorder NOS
  - conduct disorder (childhood or adolescent-onset)
  - oppositional defiant disorder
  - disruptive behavior disorder
- Feeding and Eating Disorders of Infancy or Early Childhood
  - pica
  - rumination disorder
  - feeding disorder of infancy or early childhood
- Tic Disorders
  - Tourette's disorder
  - chronic motor or vocal tic disorder
  - transient tic disorder
  - tic disorder NOS
- Elimination Disorders
  - encopresis
    - with constipation and overflow incontinence
    - without constipation and overflow incontinence
  - enuresis (not due to a general medical condition) -- nocturnal, diurnal, or both
- Other Disorders of Infancy, Childhood, or Adolescence
  - separation anxiety disorder
  - selective mutism
  - reactive attachment disorder of infancy or early childhood (inhibited or disinhibited)
  - stereotypic movement disorder
  - disorder of infancy, childhood, or adolescence NOS

[1] Diagnoses of mental retardation and learning disorders must be based on use of one or more of the standardized, individually administered intelligence tests. In addition, diagnosis of learning disorders requires use of standardized, individually administered achievement tests in determining the degree of discrepancy between intellectual functioning and achievement.

[2] NOS = Not Otherwise Specified -- As indicated in the DSM: "Because of the diversity of clinical presentations, it is impossible for the diagnostic nomenclature to cover every possible situation. For this reason, each diagnostic class has at least one Not Otherwise Specified (NOS) category and some classes have several...."

Other Categories Used in Diagnosing Child and Adolescent Problems

The following are additional categories often used in diagnosing young people:

- Adjustment Disorder *
  - with depressed mood
  - with anxiety
  - with mixed anxiety and depressed mood
  - with disturbance of conduct
  - with mixed disturbance of emotions and conduct
  - unspecified

  Specify if: acute/chronic

*The essential feature of such a disorder is described as "the development of clinically significant emotional or behavioral symptoms in response to an identifiable psychosocial stressor or stressors."

- Anxiety Disorders
  - panic disorder without agrophobia
  - panic disorder with agrophobia
  - agrophobia without history of panic disorder
  - specific phobia (specified)
  - social phobia
  - obsessive-compulsive disorder
  - posttraumatic stress disorder
  - acute stress disorder
  - generalized anxiety disorder
  - anxiety disorder due to ...
    (indicated general medical condition)
  - substance-induced anxiety disorder
  - anxiety disorder NOS

- Mood Disorders

  Depressive Disorders
  - major depressive disorder
    (single episode/recurrent)
  - dysthmic disorder
  - depressive disorder

  Bipolar Disorders
  - bipolar I disorder
  - bipolar II disorder
  - cyclothymic disorder
  - bipolar disorder NOS
  - mood disorder due to ...
    (indicated general medical condition)
  - substance-induced mood disorder
  - mood disorder NOS

- Other Conditions That May Be A Focus of Clinical Attention

  . . . .

  Relational Problems
  - relational problem related to a mental disorder or general medical condition
  - parent-child relational problem
  - . . .
  - sibling relational problem
  - relational problem NOS

  Problems Related to Abuse or Neglect
  - physical abuse of child
  - sexual abuse of child
  - neglect of child
  - . . .

  Additional Conditions that May Be a Focus of Clinical Attention
  - . . .
  - child or adolescent antisocial behavior
  - . . .
  - academic problem

For statistical (and payment) reporting purposes, assessments made using the DSM are assigned codes. For example, each of the categories listed above has a specific code assigned to it. Thus, if a youngster is diagnosed as attention-deficit hyperactivity disorder, combined type, the problem is assigned the code 314.01; if the diagnosis is conduct disorder, the code is 312.8. a special set of codes, called V codes, are used to identify individuals who have problems that require treatment but do not meet the criteria set for one of the disorders.

A summary diagnosis and coding might look like this:

Axis I	Conduct disorder -- adolescent onset (severe)	312.8
Axis II	No evident disorder	V71.09
Axis III	No apparent contribution	
Axis IV	Problems with educational setting	3
Axis V	Current functioning	GAF = 50

W. Paul Jones has written a useful little book for school staff interested in the DSM. He entitles the work: *Deciphering the Diagnostic Codes: A Guide for School Counselors* (1997, Corwin Press). In the work, he states that using the DSM really begins with the General Assessment of Functioning. That is, if the GAF is high, even if there are symptoms there is no disorder to diagnose. Axis IV is used to assess psychosocial facet, Axis III considers medical conditions, Axis II looks at persistent, cross-situational patterns of behavior or conditions that are related to symptoms. Finally, the primary focus of treatment is identified on Axis I.

Some Cautions

(1) *Diagnoses must be based on formal criteria and professional assessment.*

> Because so many terms used in formal classification schemes such as the DSM have found their way into everyday language, the words often are used without reference to formal criteria and without use of related professional assessment. For example, it is easy to fall into the trap of referring to common learning problems as learning disabilities, very active children as hyperactive or ADHD, commonplace anxieties as anxiety disorders, and sadness as depression or a mood disorder. *Use of formal diagnostic categories requires careful application of designated criteria as operationalized in formal assessments.* Such criteria have an inclusionary and exclusionary focus to facilitate differential diagnosis and are concerned with severity, pervasiveness, onset, and duration in determining whether there is a clinically significant impairment. They also stress ways of determining whether symptoms are substance -induced (through use of alcohol and others drugs/medications or as a result of toxin exposure) and what should be considered in determining whether symptoms are the result of a general medical condition.

(2) *Diagnoses should not be based on ensuring reimbursement from third-party payers.*

> In his book, W. Paul Jones (cited above) recognizes the role that third-party payment for mental health services plays in the overdiagnosis of psychopathology by requiring identification of a disorder for reimbursement. He cautions "when, for example, a parent-child relation problem is identified on Axis I as the primary focus of treatment, there is a high probability that no third-party reimbursement will be available. If the provider can

find sufficient evidence to identify another disorder on Axis I, for example, anxiety, and then list the parent-child problem on Axis IV, the probability of eligibility for reimbursement by an insurer increases dramatically. ... until or unless third-party reimbursement becomes available before problems become severe, V codes will probably be reported on Axis I at a lower rate than codes that are eligible for reimbursement."

Two cautions discussed in the DSM-IV also should be noted:

(3) *DSM diagnostic criteria are only guidelines and not all conditions needing treatment are included.*

> "The specified diagnostic criteria for each mental disorder are offered as guidelines for making diagnoses ... to enhance agreement among clinicians and investigators. The proper use of these criteria requires specialized clinical training .... [The work reflects] a consensus of current formulations of evolving knowledge .... They do not encompass, however, all the conditions for which people may be treated...."

(4) *Watch out for cultural diversity.*

> "Diagnostic assessment can be especially challenging when a clinician from one ethnic or cultural group uses the DSM-IV Classification to evaluate an individual from a different ethnic or cultural group. A clinician who is unfamiliar with the nuances of an individual's cultural frame of reference may incorrectly judge as psychopathology those normal variations in behavior, belief, or experience that are particular to the individual's culture."

DSM and the International Classification of Diseases (ICD)

The *official* diagnostic classification and coding system in use in the U.S. is the *International Classification of Diseases,* 9th Revision, Clinical Modification (ICD-9-CM). Under development is the *International Statistical Classification of Diseases and Related Health Problems,* 10th Revision (ICD-10) -- developed by the World Health Organization (WHO). The U.S. Department of Health and Human Services plans to require use of ICD-10 codes for reporting purposes throughout the U.S. (probably around the turn of this century). The DSM notes that to facilitate the transition, "preparation of DSM-IV has been closely coordinated with the preparation of Chapter V, 'Mental and Behavioral Disorders,' of ICD-10 . . . ." so that the respective codes and terms are fully compatible. Appendix H in the DSM-IV provides a cross-translation.

Appendix II-3

Organizing and Training a School-Based Crisis Team

In this appendix, you will find some material on

(1) **Building a School-Based Crisis Team**

Organizational steps are outlined. Also includes
  an example of a Meeting Invitation
  an outline of the meeting's topic: *Focus on Planning*
  an example of a worksheet for the session

(2) **Crisis Team Training**

Highlights the need for both general and specialized training over time.

(3) **Two Initial Training Sessions**

Highlights the focus of the initial training by outlining the two session topics
  Focus on Action
  Focus on Prevention

Building a School-Based Crisis Team

The process of organizing a school-based crisis team begins with the site's leadership. Once there is agreement on the value of establishing such a team, someone must be designated the responsibility of building the team. That person begins by identifying those who have formal roles they must play during a crisis, those with specific skills that are needed, and any others who may be especially motivated to be part of such a team.

The next step is to set a meeting time and invite the potential members.

To increase the likelihood that the meeting is focused and productive, it helps to do some presession structuring. This includes

- asking others to play a role during the meeting (e.g., meeting facilitator, time keeper, note taker -- see accompanying sample form)
- providing them with copies of the site's existing crisis response plans and some general material to read on the subject of school-based crisis response (such as the overview presented in Section I of this resource aid).

During the meeting, it helps to use worksheets that focus the discussion on key topics and decisions about tasks assignments and timelines.

The meeting, of course, will review the site's existing crisis response plans and discuss a variety of related matters.

By the end of the meeting, agreements should have been made about team membership, roles, and decide on initial training dates and who will conduct the training.

Example of Meeting Invitation

Meeting to Organize
the School's Crisis Response Team

Date

To:

From:

As you know the school has decided to (re)organize a school-based crisis team. You have been identified as a key person to talk with about the team.

At the meeting, we will review the site's existing crisis response plans and discuss a variety of related matters. By the end of the meeting, we will clarify crisis team membership, roles, and initial training dates.

In preparation for our meeting, please review the attached material.

The meeting is scheduled for (date, day, time)

To help make the meeting run smoothly and productively, the following staff have agreed to guide the process.

Meeting facilitator will be________________________________

Meeting time keeper will be________________________________

Meeting scribe will be________________________________

Finally, since a crisis demands that we work quickly, teamwork under pressure will be good practice. This means starting and ending the meeting on time and setting time limits for each task.

Session Topic:

FOCUS ON PLANNING

What are our roles and functions as team members?

(1) Meeting facilitator reviews the key team roles and functions

(2) Decide who will take each role. (Fill in Worksheet -- see accompanying example).

If there are enough people, designate a back up for each position. Discuss *chain of command.* Who will be in charge, who will be next, if these two are not available or busy who would be third. Enter all necessary contact information (e.g., home numbers, beepers).

(3) Discuss the last crisis at the school.

If one doesn't come to mind, use the possibility of a car accident outside school involving a student and observed by most students and parents. Each team member should assume her/his role in talking through the specifics of what to do. Treat this as brainstorming with no discussion until the exercise is finished. Then take five minutes to highlight the good ideas and additional suggestions for action.

(4) Plan on a way each team member will inform others at the school about the crisis team membership and roles. For examples who will talk to faculty, parent center coordinator, office staff, TA's, Playground staff, support staff?

(5) Prepare for the next meeting which will *FOCUS ON ACTION*

Date for next meeting
Meeting facilitator
Meeting time keeper
Meeting scribe

Someone should volunteer to copy and distribute the preparation material for the next meeting.

Worksheet

Team Membership, Roles, and Functions

Roles/Functions	*Name* (One person may serve more than one role/function)	*Chain of Command* (Who's in charge? Back-ups?)	*Contact Information*
Team Leader			
Administrative Liaison			
Staff Liaison			
Communications Liaison			
Media Liaison			
First Aid Coordinator(s) medical psychological			
Communications Coordinator			
Crowd Management Coordinator			
Evacuation/Transportation Coord			

Crisis Team Training

The team as a whole should receive general training with respect to crisis intervention and team building. In addition, each subteam or designated "specialist" needs specialized training.

> The team leader should bring all members together once a month so that each can learn from the experiences and training of the others. The minutes of this meeting can be reproduced as a monthly report to the school, and this report can act as a reminder of the importance of dealing with the aftermath of crises, of who should be contacted at such times, and as an indication of the team's impact.

Besides mastering the school's crisis response plan and emergency steps, *general* training involves learning

- how to minimize student contagion in the aftermath of such a problem
- how to reassure the majority of students about the problem
- how to identify and provide psychological first aid to students who have especially strong reactions (including assisting with someone in acute shock or trauma)
- counseling skills appropriate to the event (including active listening skills, small-group techniques for both students and adults, conflict resolution, critical incident stress debriefing, support group facilitation)

Each subteam should receive *specialized* training with respect to the specific type of crisis with which the subteam is concerned (e.g., fire, earthquake, suicidal youth). Specialized training involves learning

- the types of reactions students, staff, and parents are likely to have to a particular type of crisis;
- how to respond to specific types of reactions.

Note: A special training opportunity for interested team members is to participate in a disaster drill held by local hospitals, police, fire departments, offices of emergency services, etc.

Two Initial Training Sessions

The first sessions after the organizational meeting stress specific preparation for action and prevention..

Session 1: **FOCUS ON ACTION**

What steps should we plan for?

Session 2: **FOCUS ON PREVENTION**

How can we enhance resources to prevent some crises and minimize others?

(1) Focus on Action

Prior to the session, team members are to review the material on Planning for Crisis in Section I of this resource aid, as well as the material on key considerations and the Crisis Checklists contained in Section II.

At the session(s):

1) The meeting facilitator talks through a crisis intervention flow chart. For each step, team members write in the name(s) of who on the team will be responsible for the function.

2) The meeting facilitator asks each member to talk through one section of the checklist. Briefly personalize this for the school (who, what, when, where). If this takes too long for one meeting, carry if over to a second FOCUS *ON ACTION* Meeting.

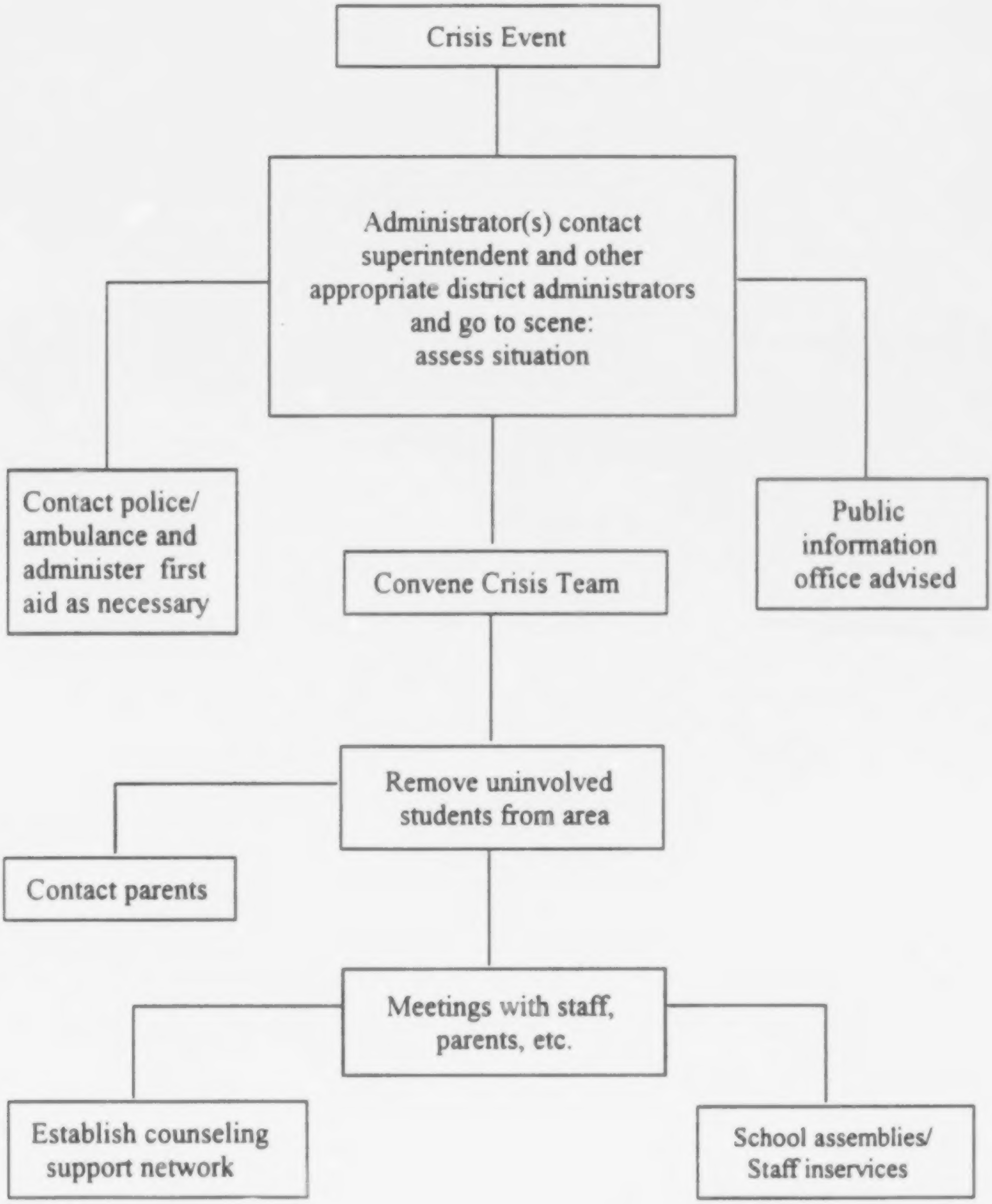
3) If there has been a crisis at the school or one has been averted or minimized, discuss it briefly. Assess what worked well and what didn't. Make any changes in the plans and decide how to inform others.

Preparation for the next meeting *FOCUS ON PREVENTION.*

Date of the meeting:	Meeting time keeper:
Meeting facilitator:	Meeting scribe:

Crisis Intervention Flow Chart

Personal/Life Threatening Event


Crisis Event
Administrator(s) contact superintendent and other appropriate district administrators and go to scene: assess situation
Contact police/ ambulance and administer first aid as necessary
Convene Crisis Team
Public information office advised
Remove uninvolved students from area
Contact parents
Meetings with staff, parents, etc.
Establish counseling support network
School assemblies/ Staff inservices

(2) Focus on Prevention

At this session(s), the discussion and training explores the following matters.

> If a crisis situation has occurred at the school, part of the time is used for debriefing (*What happened? How was it handled? What went well? What didn't? Is a change in plans needed?*).

To begin to plan ways to minimize and perhaps avert crises, the team needs to understand how existing programs might be enhanced and new ones developed. The discussion begins with the questions:

> *What are ways the school can avert or minimize crisis situations?*
>
> *Can we do so by enhancing certain programs and developing preventive approaches?*

This leads to discussion of:

> *What does the school have? Need?*
>
> *What else might strengthen the safety net?*

In this context, team members can learn to map what's in place and analyze whether it needs to be improved (e.g., Is the school's emergency plan effective? Is there a safe school plan? a Parent Center? a District Crisis Team? Is there a conflict mediation program? a human relations program? Could linkage with some community resources result in better recreation and enrichment opportunities and reduce gang violence?)

With a view to enhancing resources for all facets of crisis response and prevention, team members need to connect with community resources. As a first step, they can begin by mapping resources that can assist during and in the aftermath of a crisis (see attached worksheet).

Future training sessions should try to achieve a balance between capacity building for crisis response and pursuing ideas for crisis prevention. In terms of timing, everyone tends to be most motivated to learn in the wake of a debriefing done after a crisis. For purposes of simulated practice, the team might use any disaster drills the school carries out (e.g., fire, earthquake). As new members join, it is a good opportunity for experienced members to orient and teach them and, in the process, to review and consolidate what they have learned to date.

Starting to Map Community Resources

What resources are available in the school district and community to assist during and after a crisis? List all the community resources you know about. (Consult any resource books and look in the local phone book.)

Divide up the list and contact each to get updated information about services.*

Resource/Agency	Contact Name	Phone Number

*Add the page of Community Resources to the site's Crisis Handbook.

INFORMATION ON RESOURCES

All crisis response plans should include material on resources that can be used for (1) training purposes, (2) preventing and minimizing crises and their impact, and (3) responding during and after a crisis. Such resources include

- local agencies and professionals with relevant expertise and services
- other individuals who might supplement efforts to prevent or minimize
- video and film resources for training and as a stimulus for student discussions
- reading materials for training, student discussions, and "bibliotherapy"

The following organizations are resources for information and in some cases materials.

U.S. Dept. of Education: Safe and Drug-free School Office
555 New Jersey Ave., NW, Rm. 214b
Washington, DC 20208-5725
1 (202) 219-1547
FAX 1 (202) 219-1817

National School Safety Center
4165 Thousand Oaks Blvd., Suite 290
Westlake Village, CA 91362
1 (805) 373-9277
FAX 1 (805) 373-9277

National Alliance for Safe Schools
9344 Lanham-Severn Rd, Suite 102
Lanham, MD 20706
1 (301) 306-0200
FAX 1 (301) 306-0711

Prevention Intervention Program in Trauma, Violence and Sudden Bereavement in Childhood
UCLA Department of Psychiatry and Biobehavioral Sciences
750 Westwood Plaza
Los Angeles, CA 90024
1 (213) 206-8973
Robert S. Pynoos, MD, Director

National Crime Prevention Council
1700 K Street NW
Washington, DC 20006
1 (202) 466-6272
FAX 1 (202) 296-1356
email: shields@mail.ncpc.org

Office of Juvenile Justice & Delinquency Prevention
U.S. Dept. of Justice
633 Indiana Ave., NW
Washington, DC 20531
1 (202) 307-5911
FAX 1 (202) 514-6382
Webpage http://
ncjrs.aspensys.com:81/1/new2/aboutojj.html

Department of Health and Human Services
Public Health Service
Centers for Disease Control
Atlanta, GA 30333

The National Committee on Youth Suicide Prevention
666 Fifth Avenue, 13th Floor
New York, NY 10103
1-212-247-6910

Youth Suicide National Center
1825 Eye Street, NW, Suite 400
Washington, D.C. 20006
1-202-429-2016

American Association of Suicidology
2459 South Ash Street
Denver, CO 80222
1-303-692-0985

The Center for Suicide Research and Prevention
Rush-Presbyterian-St. Luke's Medical Center
1720 West Polk St.
Chicago, IL 60612
1-312-942-7208
David C. Clark, Executive Director

*Additional resources are listed in Our Center's Introductory Packet on *Violence Prevention and Safe Schools*

Appendix II-4

Addressing Specific Areas of Concern

In this appendix, you will find information on

(1) **Community and Gang Violence**

Presents a brief overview on anticipating violence, dealing with it when it occurs, intervening in its aftermath, violence prevention, and creating safe campuses.

(2) **Suicidal Crisis**

- A handout presenting some do's and don'ts related to students who appear suicidal and when a suicide is in progress.
- A Suicidal Assessment -- Checklist (with an accompanying checklist of steps to follow when a student is thought to be a suicidal risk).
- A brief discussion of depression and suicide as well as a few references to readings and suicide prevention curricula.

(3) **Family Violence**

A handout emphasizing child abuse and neglect as a major form of family violence and a personal crisis. Briefly highlights how child abuse and neglect are defined and lists common symptoms.

(4) **Sexual Assault**

A handout describing sexual assault as encompassing sexual abuse, rape, incest, and exposure. Indicators of this form of crisis are highlighted and the need for crisis response is underscored.

(5) **Grief and Loss**

- A handout outlining stages of grieving, ways to help students deal with loss, and ways to help bereaved students return to school.
- A related series of handouts from Genesee County Mental Health
  - >*Finding Hope Beyond Grief*
  - >*Helping to Survive Loss*
  - >*Grief: Sharing the Burden*
  - >*Helping Kids to Cope with Grief*
  - >*Families Facing Loss*
  - >*Helping Children Recover From Loss*

(6) **Hostage Situations**

A handout on things to do in immediate response to this type of crisis and how to assist the police in resolving the situation.

(7) **Post Traumatic Stress Disorder**

A handout highlighting the importance of understanding that school-age children who experience trauma directly or indirectly may experience major post traumatic symptoms and require psychological first-aid and treatment.

COMMUNITY AND GANG VIOLENCE*

Increasing concern about violence on campus has led to multifaceted intervention activity:

(1) to anticipate violence

(2) to deal with violence when it occurs and with its aftermath

(3) to prevent violence and create safe campuses

Anticipating Violence

In some instances, violence is anticipated. Schools need to have planned and rehearsed their response to such events. Take, for example, a situation where there is potential conflict between two gangs on campus. Obviously, steps should be taken to warn off perpetrators. In addition, there is a need to

- put appropriate school staff on alert
- enlist and enable those who can play a special role (e.g., cover the classes of teachers who can relate positively with gang members; recruit students who may be able to play a constructive role; solicit help from others in community who have a special relationship with gang members)
- increase the visibility of authority (e.g., staff, police)
- begin an open interchange with gang leaders and mediate between the factions
- move unresponsive student elements from the campus to another locale
- implement rumor control processes
- immediately take steps to remedy all justified grievances
- keep working with conflicting parties until a workable agreement is achieved.

Dealing with Violence and its Aftermath

Should violence occur, the first steps to be implemented are emergency mobilization and crisis response procedures (e.g., activation of security procedures). For example, a coded emergency P.A. announcement often is used to

- alert teachers to lock their doors and ask students to stay put during the emergency
- alert classified staff to assume assigned stations (e.g., at outside doors allowing only authorized persons in and helping with other specific responses)
- seek aid from community agencies.

*Also available from the Center is an Introductory Packet on *Violence Prevention and Safe Schools*.

Other tactics during the event involve

- encouraging students to verbalize their feelings
- providing a place for students to talk out their concerns
- being honest -- promise only what can be delivered.
- buying time in other ways that can help cool the situation, without violating due process

If the situation cannot be controlled, the police will have to take over.

At all times, maintain effective communications with the staff and security personnel.

In the rare case of a hostage situation, there is the additional problem of dealing with the hostage taker. Again, it is important to alert and mobilize staff. Then, the person best equipped to do so can try to make contact with the perpetrator. In communicating with the captor, however, there are some things to do and not to do:

(1) try to calm everyone, including the captor down and buy time until a trained negotiator can get there (e.g., ask captor what is wanted and restate requests; indicate you want to help the person get what s/he wants; if you can, find out who s/he is)

(2) don't confront or threaten with ultimatums

(3) personalize references to the captor and captives (i.e., try to use names and emphasize everyone involved is a person not an object -- not a hostage-taker, a hostage, or a negotiator); if s/he won't tell you, try to find out names from staff and students

(4) if it is safe to do so, quietly evacuate everyone who is not needed and close off area; otherwise direct everyone to avoid complicating the situation (e.g., to keep a low profile)

(5) get information about the physical plant ready for the police (e.g., maps, information about phones, accessways)

In providing help in the *aftermath*, special attention should be given to exploring with an individual (a) the degree of trauma s/he may have experienced (e.g., Were they directly victimized or a close friend of a victim?), (b) what specifically is bothering her/him (e.g., Are they feeling frightened, angry, guilty, vengeful?), and (c) what s/he feels might help currently (e.g., Is there someone with whom s/he would like to talk?).

After the immediate needs of those affected are addressed, the following procedures can help prevent a recurrence:

- debrief to review what happened and revise response and prevention plans as needed
- especially review channels for student grievances (Are students aware of such procedures? Are students' voices of concern really being heard and responded to?)
- maintain involvement of parents and agencies that came to school in the time of crisis
- expand involvement of school and community stakeholders in planning.

A few guidelines to highlight related to responding to crises that involve criminal acts on school grounds (including knife and gun wounds) include:

- taking care of the victim (if someone can do so, apply first-aid; do not remove a knife -- it may be preventing excessive bleeding; try to keep the individual from making the wound worse)
- quickly alerting administrators who will call 911 for appropriate assistance
- isolate the area
- being certain staff are responding to other students in ways that minimizes rumors and unrest
- preparing for the media
- informing parents/guardians -- in doing so, try to be calm. State "Your child has been hurt (not shot) and we would like for you to meet your child at the hospital (not the school)." Because you will not usually know how bad the wound is, tell them you are unsure of the extent of injury. If it is unclear where the student will be taken, tell the parent you will call back in a few minutes with the information. Keep the conversation brief. Focus on minimizing panic and avoiding stirring up a situation where someone might come running to seek revenge.

Whether a result of violence or other causes, should a death occur, the school should consider making provisions to

(1) announce
  - the occurrence
  - facts about any special circumstances surrounding the death with a view to countering rumors
  - times and places for the funeral and related services
  - times and places for grief groups and counseling

(2) provide concerned classroom teachers with guidelines for
  - sharing the experience with their classes
  - teaching about death and bereavement

(3) send representatives to
  - visit the family at home
  - the funeral and related services

(4) work with students who want to
  - express their sense of loss to each other and to the family
  - arrange a tribute or memorial
  - help the family if they are financially unable to pay death-related costs

Preventing Violence

Curriculum approaches to violence prevention provide a framework for schools to adapt for their specific needs. One such curriculum and an accompanying 1 hour training video have been developed by Dr. Deborah Prothrow-Stith. The focus is on teaching students the risks of physical violence and positive methods for dealing with anger. There are 10 lessons covered in the manual, along with related student handouts, background information, and a resource list. The lessons are entitled:

(1) There is a lot of violence in society
(2) Homicide: statistics and characteristics
(3) Exploring risk factors
(4) Anger is normal
(5) There are healthy and unhealthy ways to express anger
(6) There's more to lose than to gain from fighting
(7) What happens before, during, and after a fight?
(8) Preventing violence
(9) Fighting--what else is there?
(10) Practice throwing a curve

The manual can be purchased from Teenage Health Teaching Modules, Education Development Center, Inc., 55 Chapel Street, Newton, MA 02160.

Another approach specifically focuses on gangs with the intention of creating a *safe and neutral campus* environment. As a basis for such work, it is essential to establish a group of school staff members who are or will become educated about gangs in general and those in the immediate community.

Increasingly, schools are developing gang-oriented, safe-school programs. Such programs tend to have three major elements.

(1) Reduction of stimuli that can precipitate conflict

For example:

- dress code and conduct rules focused on minimizing blatant symbols of gang affiliation
- patrols to deter graffiti or to remove it as soon after it appears as is feasible

(2) Prevention

For example:

- educating students, families, staff about factors leading to violence at school, indicators of a student's possible gang involvement, factors that make a student a target of gang recruitment or attack, what can be done to contribute to a safe and neutral campus
- development of positive alternative opportunities for involvement to counter anti-social activity such as establishment of a wider range of course options, a peer counseling program, and so forth

(3) Corrective intervention

For example:

- establishment of support groups and after school tutoring for use on a voluntary basis and as a one time option to punishment for gang activity and major rule infractions
- referral for other forms of help such as treatment for alcohol and other drug abuse

SUICIDAL CRISIS

Students may make a statement about suicide (in writing assignments, drawing or indirect verbal expression). Another may make an actual attempt. And, some do end their lives.

Suicidal Thoughts -- What to do

Assess the situation and reduce the crisis state (see accompanying Suicidal Assessment Checklist).

The following are some specific do and don'ts if you are worried that the act is imminent.

Some do's:

- Send someone for help.
- Remain calm; remember the student is overwhelmed and confused as well as ambivalent.
- Get vital statistics, including the student's name, address, home phone number and parent's work number.
- Encourage the student to talk. Listen! Listen! Listen! And when you respond, reflect back what you hear the student saying. Clarify, and help him or her to define the problem, if you can.

> Consider that the student is planning suicide. How does the student plan to do it, and how long has s/he been planning and thinking about it? What events motivated the student to take this step?

- Clarify some options (e.g., school and/or community people who can help, e.g., a school mental health professional, a community mental health clinic or a hospital.
- If feasible, get an agreement to no-suicide ("No matter what happens, I will not kill myself." If the student refuses or the promise is vague, contact the principal or the school district.)

Some don'ts:

- Don't leave the student alone and don't send the student away
- Don't minimize the student's concerns or make light of the threat
- Don't worry about silences; both you and the student need time to think
- Don't fall into the trap of thinking that all the student needs is reassurance
- Don't lose patience
- Don't promise confidentiality -- promise help and privacy
- Don't argue whether suicide is right or wrong

Suicide in Progress -- Acting Promptly

The individual may use a gun, rope, knife, medications and other drugs, or a place from which to jump. You must act promptly and decisively.

Some do's:

- Be directive. Tell the student, "Don't do that; stand there and talk with me." "Put that down." "Now talk with me." "Hand me that." "I'm listening."
- Mobilize someone to inform an administrator and call 911 and get others to help you..
- Clear the scene.
- The administrator or a designee should contact parents to advise them their child is hurt and that you will call back immediately to direct the parent to the hospital to meet the child.
- Look at the student directly. Speak in a calm, low voice tone. Buy time. Get the student to talk. Listen. Acknowledge his or her feelings "You are really angry." "You must be feeling really hurt." "You must be feeling humiliated."
- Secure any weapon or pills; record the time any drugs were taken so you can. provide this information to the emergency medical staff or police.
- Get the student's name, address and phone number.
- Stay with the pupil; provide comfort.
- Secure any suicidal note and factually note when the incident occurred and what the pupil said and did.
- Ask for a debriefing session as part of taking care of yourself after the event.

Some don'ts

- Don't moralize ("You're young, you have everything to live for.")
- Don't leave the student alone (even if the student has to go to the bathroom).
- Don't move the student.

In all cases, show concern and ask questions in a straightforward and calm manner. Show you are willing to discuss suicide and that you aren't appalled or disgusted by it. Open lines of communication. Get care for the student.

SUICIDAL ASSESSMENT – CHECKLIST*

Student's Name:_______________________ Date:_________ Interviewer: ____________

(Suggested points to cover with student/parent)

(1) PAST ATTEMPTS, CURRENT PLANS, AND VIEW OF DEATH

Does the individual have frequent suicidal thoughts? Y N

Have there been suicide attempts by the student or significant others in his or her life? Y N

Does the student have a detailed, feasible plan? Y N

Has s/he made special arrangements as giving away prized possessions? Y N

Does the student fantasize about suicide as a way to make others feel guilty or as a way to get to a happier afterlife? Y N

(2) REACTIONS TO PRECIPITATING EVENTS

Is the student experiencing severe psychological distress? Y N

Have there been major changes in recent behavior along with negative feelings and thoughts? Y N

(Such changes often are related to recent loss or threat of loss of significant others or of positive status and opportunity. They also may stem from sexual, physical, or substance abuse. Negative feelings and thoughts often are expressions of a sense of extreme loss, abandonment, failure, sadness, hopelessness, guilt, and sometimes inwardly directed anger.)

(3) PSYCHOSOCIAL SUPPORT

Is there a lack of a significant other to help the student survive? Y N

Does the student feel alienated? Y N

(4) HISTORY OF RISK-TAKING BEHAVIOR

Does the student take life-threatening risks or display poor impulse control? Y N

*Use this checklist as an exploratory guide with students about whom you are concerned. Each yes raises the level of risk, but there is no single score indicating high risk. A history of suicide attempts, of course, is a sufficient reason for action. High risk also is associated with very detailed plans (when, where, how) that specify a lethal and readily available method, a specific time, and a location where it is unlikely the act would be disrupted. Further high risk indicators include the student having made final arrangements and information about a critical, recent loss. Because of the informal nature of this type assessment, it should not be filed as part of a student's regular school records.

FOLLOW-THROUGH STEPS AFTER ASSESSING SUICIDAL RISK -- CHECKLIST

___(1) As part of the process of assessment, efforts will have been made to discuss the problem openly and nonjudgmentally with the student. (Keep in mind how seriously devalued a suicidal student feels. Thus, avoid saying anything demeaning or devaluing, while conveying empathy, warmth, and respect.) If the student has resisted talking about the matter, it is worth a further effort because the more the student shares, the better off one is in trying to engage the student in problem solving.

___(2) Explain to the student the importance of and your responsibility for breaking confidentiality in the case of suicidal risk. Explore whether the student would prefer taking the lead or at least be present during the process of informing parents and other concerned parties.

___(3) If not, be certain the student is in a supportive and understanding environment (not left alone/isolated) while you set about informing others and arranging for help.

___(4) Try to contact parents by phone to

a) inform about concern
b) gather additional information to assess risk
c) provide information about problem and available resources
d) offer help in connecting with appropriate resources

Note: if parents are uncooperative, it may be necessary to report child endangerment after taking the following steps.

___(5) If a student is considered to be in danger, only release her/him to the parent or someone who is equipped to provide help. In high risk cases, if parents are unavailable (or uncooperative) and no one else is available to help, it becomes necessary to contact local public agencies (e.g., children's services, services for emergency hospitalization, local law enforcement). Agencies will want the following information:

*student's name/address/birthdate/social security number
*data indicating student is a danger to self (see Suicide Risk -- Checklist)
*stage of parent notification
*language spoken by parent/student
*health coverage plan if there is one
*where student is to be found

___(6) Follow-up with student and parents to determine what steps have been taken to minimize risk.

___(7) Document all steps taken and outcomes. Plan for aftermath intervention and support.

___(8) Report child endangerment if necessary.

DEPRESSION/SUICIDE

"I am sad all the time."
"I do everything wrong."
"Nothing is fun at all."
-- items from the
"Children's Depression Inventory"
(Kovacs & Beck, 1977)

Mental health professionals are very sensitive to symptoms of depression -- probably because of the possibility of suicide. In determining whether students are depressed, it is important to differentiate commonplace periods of unhappiness from clinical depression. It is also important to recognize that not all students who commit suicide are clinically depressed and that most persons who are unhappy or depressed do not commit suicide.

As a first step toward differentiating among the large number of teens who will report dissatisfaction with their life, it is useful to develop a clear understanding of the normative concerns of students in a specific school and community. Many students living in ghettos where daily living and school situations often are horrendous can be expected to be quite unhappy with such conditions and certainly deserve to be helped. The help needed, however, is not primarily psychotherapeutic; the need is for major changes in socioeconomic and educational conditions. Mental health professionals have a role to play here. But it is primarily one of working with others to improve such conditions -especially ways the school might improve its programs to counter frustration, unhappiness, apathy, and hopelessness and expand opportunities for students to increase expectations about a positive future.

Help for students enrolled in school-based health centers -- counseling or referral for counseling -- must be reserved for those whose problems, regardless of cause, go beyond the norm. (See Weiner, 1989, for a broad perspective on understanding the causes of depression and implications for treatment.)

School-based health center personnel can contribute to school-wide preventive programs through mental health education for students and parents and consultation and in-service for school staff. Such activity (1) encourages greater awareness of students' emotional states, especially reactions to stress, and (2) teaches individuals how to be supportive of each other through active listening, not minimizing others' feelings, and helping others problem solve rather than offering them glib advice.

With specific regard to suicide, there are school prevention programs, curricula, and audiovisual aids to draw on as resources. (If you need references, see Selected Resources from our Center.) A unit focused on suicide prevention might be included in a variety of courses. School staff, students, and parents can be taught to watch for danger signs. Teachers, other school support staff, and peer counselors can be taught how to hold discussions with upset students in the aftermath of a suicidal event. If community-based suicide prevention services -- such as hotlines and counseling -- are available, they can be advertised periodically; otherwise, efforts might be directed at helping the school or district establish such services.

On a more individual level, students who can't cope adequately because of the way they are thinking and feeling or who have made suicide attempts or who report concrete plans to do so require immediate intervention. Students who are extremely upset, but not seen as at risk for suicide, may require a few individual or group sessions with a trained professional -- from the school staff (e.g., psychologist, counselor, specially trained teacher), from the school-based health center staff, or from outside the school setting.

To evaluate suicidal risks in need of immediate attention (possibly hospitalization), the following areas have been consistently stressed (e.g., see Davis, 1985, Spirito et al., 1989; also see the preceding checklists):

(1) Past attempts, current plans, and view of death
(e.g., Does the individual have frequent suicidal thoughts? Have there been suicide attempts by the student or significant others in his or her life? Does the student have a detailed, sophisticated plan? Does s/he have the means? Has s/he made special arrangements to leave this world, such as giving away prized possessions? Does the student fantasize about suicide as a way to make others feel guilty or as a way to get to a happier afterlife?)

(2) Reactions to precipitating events
(e.g., Is the student experiencing severe psychological distress? Have there been major changes in recent behavior along with negative feelings and thoughts? Such changes often are related to recent loss or threat of loss of significant others or of positive status and opportunity. They also may stem from sexual, physical, or substance abuse. Negative feelings and thoughts often are expressions of a sense of extreme loss, abandonment, failure, sadness, hopelessness, guilt, and sometimes inwardly directed anger.)

(3) Psychosocial support
(e.g., Is there a lack of a "significant other" to help the student survive? Does the student feel alienated?)

(4) History of risk-taking behavior
(e.g., Does the student take life-threatening risks or display poor impulse control?)

In approaching individuals seen as potentially suicidal, there is considerable agreement about steps to be taken. To begin with, Sandoval, Davis, & Wilson (1987) stress (in an article entitled "An overview of the school-based prevention of adolescent suicide"):

> **"...it is important to make some kind of immediate contact with the student. Remaining silent and ignoring these behaviors are the worst thing one can do. An open discussion will rarely make a situation worse. The first step in suicide prevention at this level is to begin an open and frank discussion about how the individual is feeling. It is particularly important to avoid 'trying to talk someone out of suicide.' For example, it is a mistake to tell a student, 'Everything will be all right,' 'You will feel better in the morning,' or 'You really have a great deal to live for and are fortunate compared to others in the world.' Giving messages of this kind make the individual feel even more worthless and hopeless than before."**

Students at risk for suicide usually require relatively long-term individual or group counseling. Thus, referral to outside resources usually is required. The health center staff can play a useful role in meeting this need by developing an effective referral system and establishing appropriate support procedures to ensure follow-through. In addition, center staff may be able to help establish ongoing life support groups to supplement and continue support when counseling ends.

BEST COPY AVAILABLE

For more help with these problems, send for the Center's Consultation Cadre list and contact center staff. Among the material already referenced in our Clearinghouse are a suicide program bulletin and a prevention curriculum (and related teacher's guide and training videotape) developed by the Los Angeles Unified School District (LAUSD, 1987a; 1987b). The curriculum is designed to (1) help students understand suicidal feelings and ideation and how to cope better and (2) teach them to help others who seem depressed/suicidal by responding appropriately and using available resources at school and in the community. The curriculum includes two 50 minute class lessons which can be integrated, for example, into a 10th grade health education course.

References Cited Above Related to Depression/Suicide:

Davis, J. (1985). Suicidal crises in schools. *School Psychology Review, 14*, 313-324.

Fellner, R.D., Adan, A.M., & Silverman, M.M. (1992). Risk assessment and prevention of youth suicide in schools and educational contexts. In R. Maris, A. Berman, J. Maltsberger, & R. Yufit (Eds.), *Assessment and prediction of suicide* (pp. 420-447). New York: Guilford Press.

Herring, R. (1990). Suicide in the middle school: Who said kids will not? *Elementary School Guidance and Counseling, 25*(2), 129-137.

Hicks, B.B. (1990). *Youth suicide: A comprehensive manual for prevention and intervention.* Bloomington, Indiana: National Educational Service, Inc.

Kovacs, M., & Beck, A. (1977). An empirical-clinical approach toward a definition of childhood depression. In J. Schulterbrandt & A. Raskin (Eds.), *Depression in childhood: Diagnosis, treatment, and conceptual models* (pp. 20-23). New York: Raven.

Komar, Arne A. (1994). Adolescent school crises: Structures, issues and techniques for postventions. *International Journal of Adolescence & Youth, 5*(1-2), 35-46.

Mikow, V. (1995). *Selected indicators of adolescent suicide in high school students: Results of the 1993 North Carolina Youth Risk Behavior Survey.* Raleigh, NC: North Carolina State Dept. of Public Instruction, Division of Development and Evaluation Services.

LAUSD (1987a). *Crossroads: Coping with crisis: Teacher's guide for the Youth Suicide Prevention Program.* Pub. No. X-129.

LAUSD (1987b). *Crossroads: Coping with crisis: Personal wellness handbook for the Youth Suicide Prevention Program.* Pub. No. X-130.

Poland, S. (1989). *Suicide intervention in the schools.* New York: Guilford Press.

Range, L.M. (1993). Suicide prevention: Guidelines for schools. *Educational Psychology Review, 5*(2), 135-154.

Ryerson, D. (1990). Suicide awareness education in schools: The development of a core program and subsequent modifications for special populations or institutions. Special Issue: Suicide prevention in schools. *Death Studies, 14*(4), 371-390.

Sandoval, J., Davis, J., & Wilson, M. (1987). An overview of the school-based prevention of adolescent suicide. *Child & Youth Services, 10,* 103-120.

Spirito, A., Brown, L., Overholser, J., & Fritz, G. (1989). Attempted suicide in adolescence: A review and critique of the literature. *Clinical Psychology Review, 9,* 335-363.

Thompson, R.A. (1995). Being prepared for suicide or sudden death in schools: Strategies to restore equilibrium. Special Issue: Disasters and crises: A mental health counseling perspective. *Journal of Mental Health Counseling, 17*(3), 264-277.

Tierney, R., Ramsay, R., Tanney, B., & Lang, W. (1990). Comprehensive school suicide prevention programs. Special Issue: Suicide prevention in schools. *Death Studies, 14*(4), 347-370.

Weiner, M. (1989) Psychopathology reconsidered: Depressions interpreted as psychosocial transactions. *Clinical Psychology Review, 9,* 295-321.

Selected Resources from our Center

Resource Aid Packet on Screening/Assessing Students: Indicators and Tools

Designed to provide some resources relevant to screening students experiencing problems. In particular, this packet includes a perspective for understanding the screening process and aids for initial problem identification and screening of several major psychosocial problems such as depression/suicide.

Resource Aid Packet on Responding to Crisis at a School

Provides a set of guides and handouts for use in crisis planning and as aids for training staff to respond effectively. Contains materials to guide the organization and initial training of a school-based crisis team, as well as materials for use in ongoing training and as information handouts for staff, students, and parents.

Introductory Packet on Assessing to Address Barriers to Learning

Discusses basic principles, concepts, issues, and concerns related to assessment of various barriers to student learning. It also includes resource aids on procedures and instruments to measure psychosocial, as well as environmental barriers to learning.

FAMILY VIOLENCE

Family violence takes many forms and includes child abuse and neglect.

Family Violence

Any intentional mistreatment of one family member by another constitutes family violence. It may include neglect, sexual abuse, and verbal and psychological abuse. It may range from mild to lethal.

Child Abuse and Neglect

Legally, most school professionals are mandated to report child abuse, but because family violence is so widespread, it is often not seen as crisis. Yet, when family violence occurs, it can be experienced as a major trauma by a child.

Abuse occurs when a child's caretaker through willful neglect or intention causes the child to be injured or places the child in danger.

Abuse includes

- causing internal and external physical injury (watch for students who, more often than their classmates, have large bruises, serious lacerations, burns, fractures)
- causing neonatal addiction to drugs
- deprivations that cause failure to thrive (growth and developmental delays)
- sexual abuse.

Causing serious emotional trauma also constitutes abuse.

Chronic problems or abrupt changes in behavior may be indicators of child abuse. Watch for children who, more often than their classmates, are

- restless
- negativisti, unresponsive, and anti-social
- dejected and self-deprecatory
- fearful/withdrawn
- compulsive
- apathetic
- apt to provoke others to attack

Any form of family violence may be experienced as a major trauma by a child. Sometimes such children act out what they have observed -- physically and sexually abusing others.

Neglect is chronically not attending to a child's basic health or welfare needs (failure to provide nurturance and safety; adequate food, clothing, and shelter; appropriate medicine and education). Caretakers are seen as neglectful if their attention to a child is improper or inadequate or if they fail to provide appropriate care, supervision, education, and emotional support.

In addition to symptoms of emotional, learning, and behavioral problems, neglected children often show significant indications of

- malnutrition
- fatigue/listlessness
- poor hygiene
- not having adequate clothing for the weather conditions

Report *and* Help

In meeting reporting obligations, professionals often are creating another crisis for the child. Thus, it is essential to institute an individually oriented crisis response.

Over the long run, schools need to play a greater role in developing programs that contribute to the prevention of all forms family violence.

SEXUAL ASSAULT

Sexual assault includes not only rape or incest, but also any forced physical contact with genitals and even being forced to look at genitals, undress or expose oneself. Incest is sexual assault and abuse by a family member (sibling, parent, step-parent, grandparent, uncle, aunt or other relative).

Force includes not only physical force, but use of bribes, trickery, or emotional pressure to engage someone in sexual contact or inappropriate touching. Examples of bribes are offering money, special privilege and treats.

A Few Myths Regarding Sexual Assault

Myth: Few children are sexually assaulted.

Fact: Recent findings suggest that at least one out of eight boys and one of four girls will be sexually assaulted by the age of eighteen. A rape is reported in the U.S.A. approximately once every six minutes.

Myth: Victims provoke their sexual abuse.

Fact: No one has a right to hurt another. The attitude that victims are partly responsible makes them feel at fault and makes others treat sexual assault as a lesser crime.

Myth: Discussing sexual assault is bad for children.

Fact: Inaccurate or false information is bad for anyone. Informing children about sexual abuse can be seen as basic safety information and a facet of prevention.

Indicators of Sexual Abuse

Any common symptoms of learning, behavior, and emotional problems may be an indicator of sexual abuse. Professionals often are told to watch for children who indicate they don't want to go home or want to stay with you or who make unusual statements about their contact with specific adults.

> "S/he wears funny underwear." "S/he told me everyone does it and showed me pictures." "S/he said I mustn't tell anyone -- or else."

A few other possible but obviously fallible indicators are:

- Young children with unusual knowledge of sexual topics
- Unusual interest in the genitals of people or animals
- Public masturbation/promiscuity with peer
- Difficulty in walking or sitting
- Pain or itching in genital area or other stress-related somatic complaints
- Regression to infantile behavior (thumb sucking, baby talk)
- Sleep disturbances (nightmares, bedwetting, fear of sleeping alone)
- Eating problems

Students who are raped report feeling powerless and fear being killed or seriously injured. Afterward, the feeling of vulnerability continues and may be accompanied with shock and disbelief, sleep disturbances, flashbacks, mood swings, difficulty concentrating, guilt, shame, and self-blame. These symptoms may not occur immediately but may arise days or weeks after the rape.

Crisis Response

If a student has just been raped, the first crisis responses are to ensure safety, arrange for medical treatment, and report the matter to the proper authorities.

Subsequent crisis response for all sexual assaults must include intervention to ensure victimization does not recur. Crisis counseling and aftermath therapy can assist victims in understanding what they are going through and will likely experience; this can prevent exacerbation of the problem and help speed up recovery. One paradox of discussing assault with a victim is that some experience a crisis of disclosure. It helps to ensure privacy and as much confidentiality as is appropriate (remembering that a few key professionals will need to know if they are to help).

GRIEF AND LOSS

Students experience a variety of losses -- some of which are so significant as to lead to grief reactions. Students manifesting major grief reactions are experiencing a personal crisis.

Stages of Grieving

Grieving disrupts a students normal functioning. But it need not be a long lasting problem and "working" through grief can help restore emotional health. Although the stages of grief may not occur in order, they have been described as follows:

- *Shock* -- usually the first reaction -- often experienced as numbness or physical pain and associated with withdrawal.
- *Denial* -- acting as if no loss has occurred
- *Depression* -- feeling pain, despair, emptiness -- may not be accompanied by some emotional release such as crying (if the person can cry, it helps release stress)
- *Guilt* -- self-blame for not having expressed more caring or belief the loss was his/her fault
- *Anxiety* -- panic reactions as reality sets in
- *Aggression* -- toward those who might have prevented the loss and sometimes toward the lost object (may have trouble acknowledging anger toward the object of loss, but if such anger can be expressed it can help with recovery)
- *Reintegration* -- loss is accepted (although there may be periods of relapse).

Helping Students Deal with Loss

One of the most difficult losses is the death of someone who was loved. As in all loss situations, grieving students need to experience school as a safe place to think about and express their loss. To this end, crisis counselors and other school staff need to be prepared to

(1 Recognize the loss and encourage students to talk about what about what happened and how they are feeling. ("Tell me what happened." "I'm so sorry")

(2) Tell them as a group what happened and respond emotionally. Directly relate the facts and let them know how you feel. ("It hurts to know your mother died.")

(3) Allow students to express their reactions and be prepared to validate the variety of emotions that will emerge in relation to each stage of grieving. Offer time for students to share their feelings and facilitate the exploration. When working with groups, validate the feelings expressed -- even if they seem harsh. (Students will express anger, fear, guilt, and so forth. Sometimes, they will even indicate relief that what happened to someone else didn't happen to them. Others may find it hard to express anything.) Responses should be warm and understanding. Students need to told it is O.K. to cry.

(4) Be prepared to answer questions directly and sensitively. Relate the facts of an event to the degree that you can. In discussing death, recognize its finality -- don't compare it with sleeping (that can lead to sleep problems for students).

(5) In the situation where a student is returning to school after experiencing the death of a cherished other, be sure that classmates have been prepared with respect to what to say and how to act. It is critical that they welcome the student and not shy away ("Glad you're back, sorry about your brother." "When you feel like it, let's talk about it.").

(6) Don't forget to take care of yourself -- especially if the loss is one for you too.

Helping Bereaved Students Return to School

Students experiencing loss sometimes don't want to go to school anymore. There are many reasons for this. Crisis response plans should address what to do to maximize a student's return after a loss.

(1) Outreach. A home visit can help assess needs and how to address them. A step-by-step plan can be made with the student's family.

(2) Special support and accommodations at school. Teachers and other staff need to be informed as to the plan and of ways to help the student readjust. Connecting the student to special friends and counselors who will be especially supportive. Ensuring that everyone understands grief reactions and is ready to be appropriately responsive. Added support around classroom learning activities can help if the student is having trouble focusing.

(3) Counseling to help the student through the stages of grief. In general, the student needs to have prompt and accurate information about what happened, honest answers to questions, an opportunity to work through the grief, and lots of good support.

Handouts on Grief and Loss

Included here are some well-designed handouts for students and staff developed by the Genesee County Community Mental Health agency.

Lifeworks

Finding Hope Beyond Grief

You have experienced a loss whether it be a loss of a relative or a friend; or as a rape, assault, violence victim; or in moving or changing jobs. There are many situations which can lead to loss and it is important to note there are many kinds of loss. A loss of a friendship, loss of dignity, loss of independence, or a loss of trust are just a few examples.

Understanding loss is a healing process which you need to work toward. The time it takes for an emotional wound to heal varies from person to person. The healing process is best done openly and honestly. The following suggestions may help ease recovery for adults and teens.

1. **Let your friends and family help you.** Take advantage of their offers to help you. It makes them feel good, they are doing something for you.
2. **Share your feelings.** If you are feeling overwhelmed, talk it over with a trained counselor or another bereaved person. Objectivity is often helpful.
3. **Do not use alcohol and drugs.** The work of mourning does not proceed while you are numb. It resumes when sedation wears off.
4. **Work on acknowledging reality.** Tell yourself, "It happened. I have to deal with it."
5. **Anger is natural.** Try to keep it in focus.
6. **Try to replace "why" with "what"?** Stop looking for causes and begin to think about next steps. Ask, "What do I do now?" The answer may be "nothing," and that's normal. One day at a time is all you can manage.
7. **Begin your what with small questions.** "What should I wear?" for example.
8. **Pain is part of the process, accept it.** It will be bad, but pain is a by-product of the healing process — like the pain you feel when a broken bone is mending.
9. **Give yourself quiet time.** You will need time alone to let your mind run free, let it roam. Don't fight. This will help you heal.
10. **Adjust to your own time frame.** You cannot rush the grieving process. Listen to your innerself and your feelings.
11. **Remind yourself of your worth.** Take good care of yourself emotionally, physically, socially and mentally.
12. **Be ready for relapses.** You will wake up one day feeling good and think it is over. It is not. Later that day you may feel a vivid reminder. Do not despair. Healing takes time. Be patient with yourself.

For the person experiencing loss, life has changed significantly and there are many adjustments to be made. It takes time and patience to deal with a significant loss. Following the suggestions above should take away some of the pain and stress associated with these types of experiences.

For Your Well Being!

GENESEE COUNTY COMMUNITY MENTAL HEALTH
PREVENTION & INFORMATION SERVICES
420 W. Fifth Avenue • Flint, Michigan • (313) 257-3707

BEST COPY AVAILABLE

Lifeworks

HELPING TO SURVIVE A LOSS

Death is never easy to deal with but it is a part of life. The loss of a loved one is one of life's most stressful events. Because of the pain associated with someone dying, it is important that you know how to confront and acknowledge the intense emotions of those times.

All people go through a process of grief when someone close dies. Grief is a natural, healthy response to a significant loss in our lives. Although the grief process is never the same in everyone, certain feelings are common. These feelings include shock, denial, anger, guilt, depression, loneliness, and hopefully, acceptance. Usually people can get through the grieving process alone, but sometimes there is a need for professional help to understand the "facts of death".

The period of bereavement is not an easy one for anybody. Family members need to be consoled and helped through the traumatic ordeal. Here are some things you can do to help the grieving process go smoother for those closest to the deceased.

1. Listen. Allow the grieving person to talk openly about the person who has died, the death, etc. if that is what they want to do. There is no right or wrong way to grieve. While some people are very talkative, others are quiet and introspective. Remember, it's more important for you to be a help than a hinderance during this time.

2. Be present. Your mere presence can sometimes be of more comfort than you realize. Giving a hug or holding hands can be a tremendous source of support. If you can't be with the grieving person, call, write or send flowers or a sympathy card. These and similar gestures will be appreciated.

3. Be patient. The grieving process takes time. Each phase must be addressed. Don't try to rush the person through it or try to protect them from their loss. As hard as it may be to watch, the pain and the waiting are necessary to their recovery from their loss.

4. Offer sincere support. Be certain you are of comfort to the grieving person. Supportive remarks would include "It takes time", "I know you'll miss your loved one and your life together, I will too" and "She was such a good person". Comments like "It was his time to go" or "You'll get over it with time" probably won't comfort the grieving person.

5. Be useful. You can take some of the pressure off of the grieving person by taking care of household chores, assisting with thank-you notes, helping with meals and answering the telephone. Someone who is experiencing the death of a loved one may not feel like attending to these tedious activities.

If you would like more information on helping someone deal with their grief, or you need help in getting through your own grief process, call (313) 257-3740. A professional counselor is there to listen and help.

For Your Well Being!

GENESEE COUNTY COMMUNITY MENTAL HEALTH
PREVENTION & INFORMATION SERVICES
420 W. Fifth Avenue • Flint, Michigan • (313) 257-3707

BEST COPY AVAILABLE

Lifeworks

GRIEF

Sharing the Burden

Grief is a healthy, natural and necessary reaction to a significant change or loss in life. Many situations can result in grief: death of a family member or friend, divorce, injury, loss of a job, or giving up a dream.

There is a great deal that you and your family can do to help those close to you cope with grief. Try to place yourself in the grieving person's situation. Decide what type of support would be most helpful.

Grief is a painful experience. The time it takes for an emotional wound to heal varies from person to person.

Many experts like to list stages of grief. There is no real order to the grieving process. It is better to think of grief as a cluster of reactions.

You can help by understanding what grieving people c monly experience

An immediate response is probably shock and numbn Often it is difficult to believe the loss has happened.

Feelings of anger toward themselves and others for preventing the loss are typical.

It is common for those grieving to blame themselves something they did or didn't do prior to the loss.

Feelings of depression are often prevalent. Many times gr ing people are unwilling to perform even routine ta because of a lack of motivation.

Increased responsibility leaves the grieving person won ing where to begin or turn.

Eventually the grieving person will begin to accept the lo remember with less pain and focus on a future filled w hope.

Helping partnerships are essential to easing and sharing t burden of grief. Immediately following a change or loss t grieving person needs to accept support from fam members, friends or a minister.

Gradually family members and friends return to their live For the grieving person, life has been changed permanent and there are many adjustments to be made. As numbnes wears off, often comforting friends and family members m no longer be close by.

Ways You Can Help Someone With Grief

- Show you care by giving the person a hug.
- Empathize. Be a good listener.
- Be patient.
- Talk about similar experiences you have had.
- Provide practical assistance with everyday chores.
- If you feel your loved one may need additional advice, counselor can listen and help with setting new goals an adjusting to the loss. Call (313) 257-3740, a counselor always available.

Recovery takes time. People often need the most help afte the initial shock of a loss. Continue to provide support for a long as it's needed.

For Your Well Being!

GENESEE COUNTY COMMUNITY MENTAL HEALTH
PREVENTION & INFORMATION SERVICES
420 W. Fifth Avenue • Flint, Michigan • (313) 257-3707

BEST COPY AVAILABLE

HELPING KIDS TO COPE WITH GRIEF

PARENT
TALK

A lot of people have very wrong ideas when it comes to helping children to deal with grief. Sometimes these misconceptions can prove to be more damaging than helpful. Listed here are several myths commonly associated with grief. We have offered some alternatives to help you if you are helping a child or young person who is grieving or if you have lost a loved one.

Myth #1: Tears are a sign of weakness.

Tears are a very normal way to release the intense emotions a grieving person is feeling inside. Encouraging a child to withhold his or her feelings is encouraging potential emotional problems.

Myth #2: It is best to avoid talking about the death with or around a child who is grieving.

People who are grieving the loss of a loved one usually are grateful to those who keep memories alive, and who are not afraid to talk about the death. Depending on the age of a child, he or she may want to know more about the deceased person or details about the death.

Myth #3: Once you're over the grief process, you have stopped caring about a loved one.

Recovering from a significant loss is healthy. The love a youngster has developed for someone close who has died will last long after they have gotten over the shock of the death.

Myth #4: Children should be sheltered from grief.

Kids need to vent their feelings about the loss of a loved one just like adults. According to their age, adults need to explain the loss and the grieving process to children. This will help them to better understand the feelings they are experiencing that they are not accustomed to.

Myth #5: The grieving process is the same for everyone and you can identify each phase in order.

The grieving process is a very complicated one and differs from person to person. You will not see a grieving child changing neatly from one defined stage to another. In fact, it is common for people to drift back and forth between the stages of anger, denial and acceptance.

The loss of a loved one, whether it is a parent, grandparent, sibling or other relative, can be especially difficult for children. Death is one of life's most stressful events and is a period which needs to be handled with extreme sensitivity. If you know a young person who is grieving or you need some help getting through this tough time yourself, call (313) 257-3740. A professional counselor is always there to help.

For Your Well Being!

GENESEE COUNTY COMMUNITY MENTAL HEALTH
PREVENTION & INFORMATION SERVICES
420 W. Fifth Avenue • Flint, Michigan • (313) 257-3707

BEST COPY AVAILABLE

PARENT
TALK

Families Facing Loss

Imagine that your family has just experienced a loss of some kind. Will you know how to handle the intense emotions that accompany a crisis? Different family members may have different reactions to a loss. These responses may range from anger and denial to shock and depression. It is natural to have many reactions to a loss.

Losing someone or something close is different for a youngster than for an adult. A crisis to a young person might seem trivial to a parent or older sibling. Moving to a new neighborhood, changing schools, losing close friends, losing a pet or a favorite teacher or the loss of a meaningful object are examples of traumatic events in a young person's eyes. Because they view crises differently, children m react in ways that adults may not understand.

In response to a crisis, your 3-10 year old child may:

1) become more active and restless or easily upset;
2) become quiet or withdrawn - not wanting to talk about their experience;
3) be afraid of loud noises, rain, thunderstorms, etc.,
4) be angry and act out by hitting, screaming and throwing;
5) feel guilt that he may have caused the loss because of a previous wish or past behavior;
6) worry about what will happen to them;
7) be afraid to be left alone or to sleep alone;
8) revert to infant behaviors - thumb sucking, bed wetting, wanting a bottle, wanting to be held;
9) experience symptoms of illness - nausea, headache or fever.

Children can experience the same heightened emotions as you do following a significant loss or change. If the loss occurred suddenly, emotions tend to be intensified because the child was not prepared for it. This is a time for increased sensitivity to your child's feelings. You may want to leave a night light on for your child, rock him or her to sleep and be a little lenient with household rules.

Most reactions to a crisis or loss are normal and need to be handled with sensitivity and tolerance. No matter what the crisis or loss is, i is hard for children to understand what has happened. Some youngsters, depending on their age, will need your continued guidance and understanding to help them through the experience How you help your child may have a lasting effect.

If your child has experienced a loss at home, be sure to share tha information with your child's school teacher. No matter what the situation is, it is always helpful to have someone to talk problems out with. You may need to seek professional assistance. Call (313) 257-3740 to talk to a trained counselor who will listen to your concerns.

For Your Well-Being!

GENESEE COUNTY COMMUNITY MENTAL HEALTH
PREVENTION & INFORMATION SERVICES
420 W. Fifth Avenue • Flint, Michigan • (313) 257-3707

BEST COPY AVAILABLE

PARENT
TALK

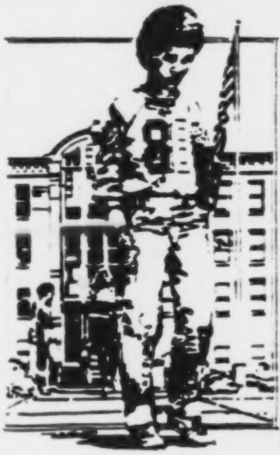
Helping Children Recover From Loss

Sometimes during a family crisis, children may get lost in the shuffle and confusion. Unfortunately, they are left to deal with a significant loss alone which can be damaging to the child. Adults and children need help coping with a loss whether it's a death, a move to a new neighborhood or school, divorce, etc., but children are especially vulnerable to the effects of such a loss. A child may have experienced a loss at school like a friend who has moved away or a favorite teacher who has been replaced.

While most parents would like to shield their child from the details of a crisis of any kind, it is much better to be open and honest with him or her. It is important that the loss is explained in terms the child can understand.

You can help your child through a crisis by:

1) **Talking with him or her.** Give correct and simple information. Allow him or her to tell their stories of what has happened.
2) **Listening** with a neutral perspective to what he or she is saying and how he or she says it. This helps you and your child clarify feelings. You may say, "How does (the loss) make you feel?" to elicit feedback from your child.
3) **Reassuring him or her.** Help him or her feel safe and secure. You may need to repeat this reassurance many times: "We are together and we will take care of you."
4) **Providing physical comfort.** Touching, hugging and contact is important during this time.
5) **Observing your child at play.** Listen to what is said and how the child plays. Frequently, children express feelings of fear or anger while playing with toys or friends.
6) **Providing play which relieves tension.** Allow the child to play with playdough, paint, pillows, balloons or balls.
7) **Allowing your child to grieve and mourn.** Giving a child the opportunity to express feelings is important to good emotional growth. Telling a child to "grow up" or "be a big boy/girl" can be detrimental to a child's emotional recovery.



You can help your child the most through a crisis situation by including him or her in the grief and recovery process. Children are very perceptive and may feel that they are being left out because the crisis was their fault. If you sense your child feels guilty or responsible for the loss, you may need to relieve them of their burden. You may have to say, "Maybe what you said or did wasn't nice, but you are not responsible for this." A loss is more difficult to deal with when there is regret or guilt.

This is a time for increased sensitivity to your child's feelings. You may want to leave a night light on for your child or rock him or her to sleep. It may also help to be a little lenient with household rules.

If your family has recently experienced a crisis or a significant loss and you need help dealing with your feelings and those of your children, call (313) 257-3740. A professional counselor is there to help in any way possible.

For Your Well Being!

GENESEE COUNTY COMMUNITY MENTAL HEALTH
PREVENTION & INFORMATION SERVICES
420 W. Fifth Avenue • Flint, Michigan • (313) 257-3707

BEST COPY AVAILABLE

HOSTAGE SITUATIONS

Fortunately, hostage situations are rare. Nevertheless, crisis response plans need to specific what to do until the police arrive and what to do to assist the police.

Immediate Response

(1) Call 911.

(2) Activate crisis response -- being very careful not to sound alarms that might cause others to move into dangerous areas. The first priority is safety and care of students and staff.

(3) Seal off the area.

(4) Avoid confronting or in any way further agitating the hostage taker.

(5) In talking with the hostage taker:

- keep your voice calm and try to keep the conversation from being in any way threatening;
- express concern ("I'm concerned about you and those with you." "What is it you would like us to do?");
- refer to captives only in people terms (children, boys, girls, women, men). This may help the hostage taker to keep thinking of them as human beings -- not objects);
- acknowledge and restate the captor's requests;
- avoid making promises or commitments (but if pushed to respond, do so agreeably and diplomatically).

Above all else try to buy time and keep the situation from getting worse while waiting for the hostage negotiators to arrive.

(6) Evacuate the area/school only if absolutely safe and secure routes are available. If evacuation is not feasible, direct everyone to stay put, stay down, and stay out of sight.

To Assist the Police

If there are witnesses, the police will appreciate having them readily accessible. Such individuals can help clarify the current situation and what happened. (In this regard, they will need to be sequestered in a safe place, with a supervision who can both provide emotional support and can keep them from talking with each other in ways that will lead to distorted recall.) If the hostage taker is known to the school, the police will also want to talk to anyone who knows the person and may want any school records on the individual and on the hostages.

The police also will want maps and the person who knows the most about the physical school plant so that they can clarify the location of doors, windows, hallways, closets, roof access, basements, control panels, fire extinguishers, communication links, and so forth.

Finally, the police will problem want to handle the media but may want someone from the school to be available.

POST-TRAUMATIC STRESS DISORDER

There is increasing concern that post-traumatic stress is not just an adult problem.

School-age children who experience trauma directly or indirectly may

- *re-experience the trauma* (intrusive imagery or sound or a full re-experiencing of a violent incident).
- *experience a numbing of responsiveness* physically and emotionally (becoming less involved and interested in activities and people -- even close friends and parents).
- report and manifest *a variety of symptoms* (grief reactions, avoidance of things that remind them of the event, poor school performance, jumpiness and nervousness, sleep disturbances, separation anxiety related to a person about whom they are worried).

Pynoos and Nader (1988)* discuss psychological first aid and treatment for use during and in the immediate aftermath of a crisis (providing a detailed outline of steps according to age). Their work helps all of us think about some general points about responding to a student who is emotionally upset.

> Psychological first aid and treatment for students/staff/parents can be as important as medical aid. The immediate objective is to help individuals deal with the troubling psychological reactions.

---

*Pynoos & Nader (1988), Psychological first aid and treatment approach to children exposed to community violence. *Journal of Traumatic Stress, 1*, 445-473.

MENTAL HEALTH AND SCHOOL-BASED HEALTH CENTERS

Module III

Program Reporting: Getting Credit for All You Do

> *Systematic evaluation is increasingly sought to guide operations, to assure legislators and planners that they are proceeding on sound lines, and to make services responsive to their publics.*
>
> Lee Cronbach & colleagues

WHY EVALUATE?

Many staff members find evaluation to be an unpleasant and often time wasting experience. It certainly can be all that and more. On the other hand, properly designed evaluation can provide the type of information that ensures one gets credit (and support) for all that is done and allows one to show pride in what is accomplished. The purpose of this module is to explore (1) what information seems important to gather regularly in order to show that the mental health focus is both needed and is doing a good job, and (2) what procedures may be useful in gathering and summarizing such information.

Outcomes, especially for individual students, are an important aspect of all this, but much more is involved than measuring outcomes for the limited number served directly by a SBHC. And, just as a center needs to develop its mental health focus in phases, there is a need to approach evaluation in stages. It helps to start by clarifying for yourself and for others what you are trying to accomplish at a given stage of SBHC development. What is the rationale for having a mental health focus? What outcomes do you realistically expect to achieve? It is important to think about outcomes broadly and programmatically. Obviously, in the long-run, you want to help individual students overcome their problems. It is equally obvious that the more SBHCs try to address the most difficult mental health and psychosocial problems, the harder it is to demonstrate major improvement -- especially when unrealistic progress is set as the accountability standard.

Units:

A. Quality Improvement, Evaluating Outcomes, and
Getting Credit for All You Do

B. Evaluating in Stages

BEST COPY AVAILABLE

Module III

Program Reporting: Getting Credit for All You Do

Contents

Page

UNIT IIIA

Quality Improvement, Evaluating Outcomes, and Getting Credit for All You Do

- Evaluation that Fosters Quality Improvement IIIA-1
- Evaluation Focused on Results IIIA-2
  - >Student Outcomes IIIA-3
    - Outcomes Reflecting Enhanced Receptivity to Instruction IIIA-3
    - Outcomes Related to Prevention and Correction of Emotional, Behavioral, Learning, and Health Problems IIIA-5
  - >Intended Impact on Families and Communities IIIA-8
  - >Intended Impact on Programs and Systems IIIA-8

Resource Aids IIIA-9

A Few Related References IIIA-14

UNIT IIIB

Evaluating in Stages

- Stage I -- Initial Mental Health Program Development, Implementation, and Evaluation
- Stage II -- Integration with Relevant School Psychosocial Programs & Expansion of Programs, Services, and Evaluation Focus
- Stage III -- Outreach to School District/Community Psychosocial Programs and Further Expansion of Programs, Services, and Evaluation Focus
  - >Problem Screening and Analysis
  - >Problem Resolution
- Stages IV-VI
  - >IV -- Institutionalization of programs and services
  - >V -- Short-term follow-up evaluation
  - >VI -- Long-term follow-up evaluation

Resource Aids

Appendix III-1: Quality Assurance and Documenting Program Effectiveness (Excerpts from: Critical Issues Planning Conducted by the Center for School Mental Health Assistance)

Exhibits and Resource Aids for Module III

Exhibits

Unit IIIB

25. Six Stages in the Development and Evaluation of the Mental Health Focus of School-Based Health Centers

26. Stage I -- Mental Health Program Development & Initial Implementation

27. Stage II -- Integration with Relevant School Psychosocial Programs & Expansion of Programs, Services, and Evaluation Focus

Resource Aids

Unit IIIA		*Page*
IIIA-1	Intervention Impact on Students	IIIA-10
IIIA-2	Intervention Impact on Families and Communities	IIIA-11
IIIA-3	Intervention Impact on Programs and Systems	IIIA-13

Unit IIIB

IIIB-1 Daily Log Record

IIIB-2 Consultation Encounter Form

IIIB-3 Consultation Follow-up Data and Feedback Form

IIIB-4 Student Data

IIIB-5 Chart Record of Psychosocial Problems

IIIB-6 Clinic Use and Nonuse and Needs Assessment

IIIB-7 A Flowchart of a 52 Week Evaluation Process

UNIT IIIA

QUALITY IMPROVEMENT, EVALUATING OUTCOMES, AND GETTING CREDIT FOR ALL YOU DO

We approach mental health activity in schools as one facet of a comprehensive, integrated approach to addressing barriers to learning and enhancing healthy development. The intent of all such activity, of course, is to enhance outcomes for children and adolescents. However, enhancing outcomes for the large number of those in need of help usually involves addressing the systems that determine such outcomes (e.g., families, education support programs, school-based health centers, off-site services, the community at large). Moreover, it is important to proceed with a holistic perspective (e.g., viewing children in the context of families and communities). Such a perspective fosters appreciation of relationships among individuals, specific aspects of systems, and the system as a whole. Given this comprehensive orientation to mental health, it is evident that evaluation involves more than measuring outcomes for individuals served.

Broadly stated, evaluation should be planned and implemented in ways that measure outcomes and much more with a view to enhancing the quality of intervention efforts and the long-term benefits for students and society. The following sections highlight a few ideas along these lines.

Evaluation that Fosters Quality Improvement

One purpose of outcome evaluation is to provide feedback on efficacy so processes can be revised and fine-tuned. Such *formative* evaluation also includes information on participants, approaches, resources, implementation strategies, program organization, staffing, operational policies and practices. It also should include data on the characteristics of the system's "clients" -- who they are, what they want and need, how they differ from those in other locales -- as a prerequisite for effective planning and as another basis for interpreting the appropriateness of observed processes and outcomes. (That is, it is essential to understand the status of clients before an intervention is implemented, not only to be aware of their needs but ultimately to make appropriate judgments about intervention outcome efficacy.)

Thus, formative evaluation includes data gathering and analyses focused on such matters as

- needs and assets, goals and desired outcomes, resources, and activities
- challenges and barriers to mental health intervention and the integration of such interventions with other activity designed to address barriers to learning, as well as with the instructional and management components of schools and communities
- characteristics of families and children in each locale, with special focus on targeted groups
- initial outcomes.

Formative evaluation data may be gathered on and from samples of all parties who have a stake in the intervention (e.g., school staff, students and their families, other stakeholders, community agencies, and so forth). The information is used to judge the "fit" of prerequisite conditions and processes. Methods used include review of documents and records, checklists, surveys, semi-structured interviews, focus group discussions, observations, and direct assessment of clientele. A well-designed information management system can be a major aid (e.g., providing data on identified needs and current status of individuals and resources). In this respect, an advanced technology can play a major role (e.g., a computerized system that is properly designed can provide access to information in other computer-based data systems containing relevant information on clients and processes).

> To be maximally useful, a data set should allow for baseline and subgroup comparisons and include multiple variables so that findings can be disaggregated during analysis. Of particular interest are data differentiating clients in terms of demographics, initial levels of motivation and development, and type, severity, and pervasiveness of problems. With respect to process, it is useful to have data differentiating stages of program development and differences in program quality.

Optimally, the date gathered should allow for formative-leading-to-summative evaluations. Designing s formative evaluation system that over time yields summative findings facilitates ongoing planning in ways that improve processes and thus outcomes. At the same time, such an approach builds a system for validating interventions.

Evaluation Focused on Results

To begin with, it will help to clarify our definition of some terms that are used throughout this section. *Aims* are extremely abstract statements of intended outcomes that encompass many goals and objectives; this usually means an aim can only be accomplished over an extensive time period (e.g., many years). *Goals* are somewhat less abstract statements encompassing many objectives; thus, a goal usually requires a somewhat extended period of time to accomplish. *Objectives* are meant to be less abstract and more immediately accomplishable than the goal that encompasses them. A *standard* is defined as a statement about what is valued. Standards are used to (a) judge and promote quality, (b) clarify goals, and (c) promote change. In evaluating efficacy, standards are operationalized in terms of specific *criteria* upon which judgments of immediate and potential long-term efficacy can be made. *Indicators of efficacy* are measurable variables that can be accessed from various sources through use of specific data gathering strategies and tools.

> As stressed, while the intent of mental health activity in schools is to enhance outcomes for students, the work must also address systems determining such outcomes. Thus, the following discussion outlines intended impact not only on students, but on families and community, and on programs and systems.

397

Student Outcomes

Efforts to address mental health concerns and other barriers to learning include enhancing receptivity to instruction through facilitating positive academic, social, emotional, and physical development. In this section, we focus first on outcomes related to facilitating such development; then, the emphasis shifts to prevention and correction of emotional, behavioral, learning, and health problems.

(1) ***Outcomes reflecting enhanced receptivity to instruction.*** Teaching and learning are transactional. Students (and teachers) bring certain capacities and attitudes (abilities, expectations, values) accumulated and established over time. These provide the foundation upon which teaching tries to build. Students also come with current physiological and psychological states of being that can facilitate or inhibit learning at any given time. Efforts to enhance receptivity to instruction focus on ensuring there is a good instructional match with the student's capacities, attitudes and current state of being. While this is especially necessary for those manifesting serious problems, it is a fundamental concern related to all learners.

> The *aim* of enhancing receptivity to instruction involves ensuring that students have the opportunity to acquire the types of basic abilities, expectations, and values that enable learning. The aim also encompasses the need for schools to respond appropriately to variations in students' current states of being (e.g., ensuring the opportunity to learn by providing breakfast and lunch programs to combat hunger, responding to personal problems and crises with support and guidance).

As is highlighted by the goals and objectives outlined in Resource Aid IIIA-1, the ultimate aim is to ensure that students develop effective levels of functionality -- academically, socially, emotionally, and physically. (With respect to social-emotional functioning, aims are sometimes referred to as personal qualities, interpersonal functioning, the affective domain, and so forth. Physical functioning often is discussed as physical and health education.) From a developmental perspective, the aim encompasses concerns for ensuring a "healthy start," a safe school environment, preparation (readiness) for school, facilitating continued positive development in all areas, facilitating progress with respect to developmental tasks at each stage of development, enhancing areas of personal interest and strength, and fostering a psychological sense of community. As with all curricular goals, desired outcomes in these areas reflect (a) intended uses (communication, reasoning, problem solving, making relationships and connections, and creativity) and (b) factors related to intrinsic motivation (personal valuing and expectations of efficacy -- including confidence in one's abilities).

> The goals and objectives outlined in Resource Aid IIIA-1 provide a frame of reference for designing programmatic activity to facilitate development related to enhancing receptivity to instruction through facilitating positive academic, social, emotional, and physical development. It is clear that attending to such functioning is basic to preventing, treating, and remedying problems. Moreover, the goals and objectives provide direction for daily program planning and for evaluation.

Need Help: Call the Technical Assistance Center for the Evaluation of Children's Mental Health

Located at the Judge Baker Children's Center in Boston (295 Longwood Ave., Boston, MA 02115), this center is a premier resource for information on specific measures. The Center provides consultation and has a library of measures, manuals, and related articles: Phone (800) 779-8390, ext. 2139. Website -- http://tac.pie.org/T3632.

Among the measures they cite are:

Parenting Stress Index
Child Behavior Checklist
Early Childhood Assessment Tool
Family Evaluation Scale
Self-esteem measures
Cultural Competence Instrument
Diagnostic Interview Schedule for Children
Adaptive Social Behavior Inventory
Adaptive Functioning Measure
Youth Satisfaction Questionnaire

In reviewing measures, they provide detailed information on various instruments. Examples include:

1) Hodges' **Child and Adolescent Functional Assessment Scale (CAFAS)** which they indicate measures client functioning in general and in each of six psychosocial areas: "Role Performance (includes legal problems), Thinking, Behavior Toward Others/Self, Moods/Emotions, and Substance Abuse. For each subscale, service providers are asked to rate the client at the most severe level of dysfunction that has occurred at anytime in the last month. In addition, two scales have been added to assess resources of caregivers' capacity to provide for a) basic needs and b) family/social support."

2) Achenbach's **Child Behavior Checklist** which measures Externalizing behavior (directed outward -- poor behavior control, etc.) and Internalizing behavior (directed inward -- anxiety, depression, etc.). Scores for problem areas distinguish a) withdrawn behavior, b) somatic complaints, c) anxious/depressed, d) social problems, e) thought problems, f) attention problems, g) delinquent behavior, h) aggressive behavior, and i) sex problems. Scores for Social Competence distinguish school, social, and activities.

3) DeChillo's **Client Satisfaction Questionnaire (CSQ)** which is an 8-item scale that yields an overall satisfaction score and specific items that might help with quality improvement of services.

Each review also provides technical information on the psychometric properties of the instrument and discusses other relevant matters.

The assumption in pursuing goals and objectives is that optimal processes (comprehensive and integrated programs) will be used to create a match that enhances positive attitudes, growth, and learning. This applies to the full range of support available to students and families -- including specialized programs at the site, home, and community. Until a comprehensive, integrated continuum of programs and services are in place, steps must be taken to address the less than optimal conditions. From this perspective, evaluation focuses on (a) individual student outcomes (related to the goals and objectives set forth in Resource Aid IIIA-1) and (b) outcomes for all children in the catchment area (e.g., community indicators of improved health, safety and survival, emotional health, and positive social connections). In addition, there can be a focus on outcomes reflecting significant changes in support systems (e.g., measures of enhanced home involvement in schooling; indicators of enhanced integration of center and community health, social, and mental health services -- including related data on financial savings).

> Furthermore, in pursuing goals and objectives related to instructional receptivity and social-emotional and physical development, it is essential to do so in ways that value and foster rather than devalue and inhibit appropriate diversity among students. This is especially important given the diversity students bring with regard to ethnic background, gender, interests, and capabilities. Thus, another focus for evaluation is on these concerns (especially in assessing for negative outcomes). In particular, efforts should be made to measure (a) movement toward inappropriate conformity in thinking and behaving in areas where diversity is desired and (b) trends toward increased levels of other-directedness and excessive dependency.

(2) *Outcomes related to preventing and correcting emotional, behavioral, learning, and health problems.* In addition to the above goals and objectives, student goals and objectives are formulated in connection with specialized programs designed to prevent and correct emotional, behavioral, learning, and health problems. These objectives relate to the efforts of such programs to remove barriers and enable students to pursue the above goals.

> It is important to emphasize that problems become of concern because they are reflected in the student's functioning; however, the primary source of the problem often is environmental. Environmentally based problems are an especially important focus for prevention programs. Such programs are targeted to designated at-risk populations (e.g., students with older siblings in gangs, immigrant and highly mobile families who have major transition and school adjustment needs, students who experience a crisis event).

In general, then, immediate objectives in working to address emotional and behavioral problems with a view to enabling student progress often include activity designed to reduce specified barriers to school attendance and functioning. Thus, attending to mental health concerns often requires addressing practical deterrents such as health problems, lack of adequate clothing, problems in the home, working with home to increase support for student improvement, dealing with student's physical or sexual abuse, dealing with student's substance abuse, dealing with gang involvement, provisions for pregnant minors and minor parents, dropout outreach and recovery, teaching student to use compensatory strategies for learning, and so forth. And, based on the discussion to this point, hopefully it is clear that the first indicators of progress may be fewer problems related to learning, behavior, and affect.

See Resource Aid IIIA-1 for examples of key intervention goals and objectives and potential indicators of efficacy. The goals and objectives listed in the Resource Aid represent individual student outcomes that can be measured as indicators of the impact of specialized programs. Positive "side effect" outcomes worth measuring are significant changes related to (a) all children in the catchment area (e.g., community indicators of improved health, safety and survival, emotional health, and positive social connections) and (b) support systems (e.g., enhanced home involvement in schooling; enhanced integration of a school-based health center and community health, social, and mental health services -- including related data on financial savings).

Of course, additional student outcomes can be delineated and measured with respect to efforts to prevent specific types of problems. This is usually accomplished by fostering positive functioning through activities designed to enhance knowledge, skills, attitudes, and action related to healthy physical and mental development. Some of these efforts are carried out in special settings, such as school-based health centers and family resource centers. Whether or not there is a special setting, these efforts include specialized programs focused on

- home involvement to enhance social-emotional development
- peer-to-peer interventions designed to enhance social-emotional development
- early education for prenatally drug-exposed children and their families
- substance abuse prevention
- suicide prevention
- physical and sexual abuse prevention
- violence prevention
- dropout prevention and school re-entry
- STD/AIDS prevention
- pregnancy prevention
- prenatal care of pregnant minors and minor parent education
- crisis intervention and emergency responses to prevent long-term impact (e.g., PTSD) and to prevent subsequent emergencies

On Measuring Mental Health Outcomes

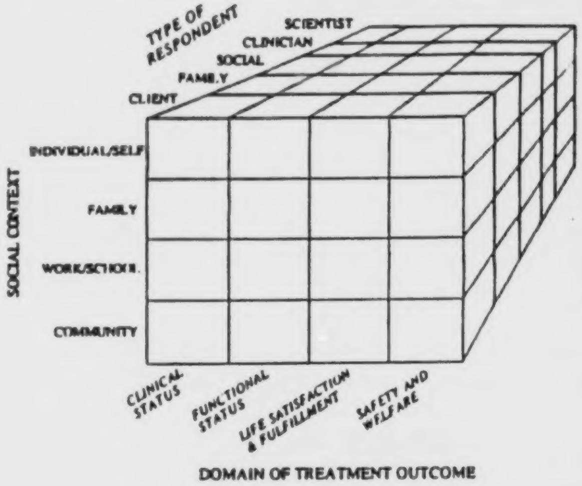
The challenges facing the field of outcome research related mental health services led Rosenblatt and Attkisson (1993)* to offer the following conceptual framework to classify the outcomes of services for sufferers of severe mental disorders. This classification framework integrates three dimensions: (a) the respondent type, (b) the social context, and (c) the domain of treatment outcomes based on the need for multiple measures and approaches to measuring outcomes for persons suffering from severe mental disorders.

The conceptual framework consists of five respondent types (who), four behavioral/social contexts of measurement (where), and four domains of treatment outcomes (what) which are graphically represented below:

Respondent types --
  measures of outcomes must reflect a range of social perspectives:client, family, social, clinician, and scientist

Behavioral/social contexts of measurement --
  measures must be taken in the context of all areas of functioning: individual/self, family, work/school, community

Domains of treatment outcomes --
  measures should cover all domains: clinical status, functional status, life satisfaction & fulfillment, safety & welfare



A model of the dimensions of outcome measurement for mental health services research.

This conceptual framework is useful in classifying and evaluating the usefulness of outcome measures, for example, who provides the data for the measure, what is the relevant social context, and what is the domain of treatment outcome?

*Assessing Outcomes for Sufferers of Severe Mental Disorder: A Conceptual Framework and Review, by A. Rosenblatt & C.C. Attkisson, *Evaluation and Program Planning*, Vol. 16, pp. 347-363, 1993.

Intended Impact on Families and Community

Aims related to families encompass promotion of positive family development and functioning and enhanced home involvement in schooling. Aims for the community encompass promotion of positive community development and functioning and related reform of community agencies (with particular emphasis on reducing problems related to health and safety). See Resource Aid IIIA-2 for examples of key intervention goals and objectives and potential indicators of efficacy.

Intended Impact on Programs and Systems

Major aims with respect to the school-site are to promote and support (a) a major restructuring of school support services, (b) integration of school support services with other school-based/linked support programs, teams, and special projects (in both the regular and special education arenas), (c) outreach to enhance linkages and collaborations with community resources (e.g., health, social, recreational programs; involvement of volunteers and local businesses), and (d) integration of all activity designed to address barriers to learning with the instructional and school management components. See Resource Aid IIIA-3 for examples of key goals and objectives and of potential indicators of efficacy.

See Appendix III-1

Our sister center, the Center for School Mental Health Assistance (at the University of Maryland at Baltimore), convenes groups of national experts for analysis and planning sessions on critical issues related to mental health in schools.

Appendix III-1 offers excerpts from sessions on:

(1) *Quality Assurance*

(2) *Documenting the Effectivenss of School Mental Health Programs*

RESOURCE AIDS

A. Resource Aids Included Here

Resource Aid IIIA-1

Intervention Impact on Students

This table outlines aims, examples of goals/objectives, and examples of incators of efficacy with specifc respect to interventions for students.

Resource Aid IIIA-2

Intervention Impact on Families and Communities

This table outlines aims, examples of goals/objectives, and examples of incators of efficacy with specifc respect to the impact of the SBHC's interventions on families and communities.

Resource Aid IIIA-3

Intervention Impact on Students

This table outlines aims, examples of goals/objectives, and examples of incators of efficacy with specifc respect to interventions for students.

B. Related Resource Aid Packets Available from Our Center.

Evaluation and Accountability: Getting Credit for All You Do!

Emphasizes evaluation as a tool to improve quality and to document outcomes. Focuses on measuring impact on students, families and communities, and programs and systems.

Cultural Concerns in Addressing Barriers to Learning

Highlights concepts, issues and implications of multiculturalism/cultural competence in the delivery of educational and mental health services, as well as for staff development and system change. This packet also includes resource aids on how to better address cultural and racial diversity in serving children and adolescents.

Intervention Impact on Students

Aims	Examples of Goals/Objectives	Examples of Indicators of Efficacy	Standards/Criteria Immediate -- Long-term
Enhance receptivity to instruction	Increase knowledge, skills, & attitudes to enhance •acceptance of responsibility (including attending, following directions & agreed upon rules/laws) •self-esteem & integrity •social & working relationships •self-evaluation & self-direction/regulation •physical functioning •health maintenance •safe behavior	Ratings by staff, family, peers Self-reports by students Performance indices (focus is on: •readiness/prerequisites/ survival skills •attendance •tardies •distractibility/ daydreaming/overactivity •dependence on others in pursuing tasks and controlling behavior •misbehavior •symptoms •negative attitudes toward self, teachers, school, peers, family, society) (Ultimately, of course, a major focus is on grades and achievement test scores.)	TO BE DETERMINED BY BIT
Prevent and correct emotional, behavior, learning, & health problems	Reduce barriers to school attendance and functioning by addressing problems related to •health •lack of adequate clothing •dysfunctional families •lack of home support for student improvement •physical/sexual abuse •substance abuse •gang involvement •pregnant/parenting minors •dropouts •need for compensatory learning strategies		

Resource Aid IIIA-2

Intervention Impact on Families and Communities

Aims	Examples of Goals/Objectives	Examples of Indicators of Efficacy	Standards/Criteria Immediate -- Long-term
Promotion of positive family development & functioning	Increase social and emotional support for families	Parents rate satisfaction with school & community programs & services designed to enhance family functioning & provide assistance	TO BE DETERMINED BY SITE
	Increase family access to special assistance		
Enhanced home involvement in schooling	Increase family ability to reduce child risk factors that can be barriers to learning	Staff rates functioning of families	
	Increase bilingual ability and literacy of parents	Frequency counts of services/ programs in operation; Performance indices	
		Staff rates functioning of families	
	Increase family ability to support schooling	Family self-reports	
	Increase positive attitudes about schooling		
	Increase home (family/parent) participation at school	Frequency counts of areas of participation and number of participants	

Intervention Impact on Families and Communities

Aims	Examples of Goals/Objectives	Examples of Indicators of Efficacy	Standards/Criteria Immediate -- Long-term
Promotion of positive community development and functioning (including influencing restructuring of community agencies)	Enhance positive attitudes toward school and community	Self-reports of community residents	TO BE DETERMINED BY SITE
	Increase community participation in school activities	Frequency counts of areas of participation and number of participants	
	Increase perception of the school as a hub of community activities	Self-reports of community residents	
	Increase partnerships designed to enhance education & service availability in community	Existence of partnership agreements & shared decision making mechanisms	
	Enhance coordination & collaboration between community agencies and school programs & services	Staff rates quality of coordination mechanisms & working relationships	
	Enhance focus on agency outreach to meet family needs	Frequency counts of students and families using programs and services	
	Increase psychological sense of community	Self-reports of community residents	
		Data from records on (a) violent acts (b) nonviolent crime (c) public health problems	

Intervention Impact on Programs and Systems

Aims	Examples of Goals/Objectives	Examples of Indicators of Efficacy	Standards/Criteria Immediate -- Long-term
Promote and support restructuring of support services (including integration with instruction & management)	Enhance processes by which staff and families learn about available programs and services and how to access those they need	Frequency counts of students and families using programs and services	TO BE DETERMINED BY SITE
	Increase coordination among services and programs	Staff rates quality of coordination mechanisms	
	Increase the degree to which staff work collaboratively and programmatically	Supervisors and staff rate how staff spends time	
	Increase services/programs at school site	Frequency counts of services/ programs in operation	
Promote and support outreach to community resources & their integration with school programs & services	Increase amount of school and community collaboration	Existence of interagency agreements & shared decision making mechanisms	
	Increase quality of services and programs by improving systems for requesting, accessing, and managing assistance for students and families (including overcoming inappropriate barriers to confidentiality)	Staff rates quality of (a) systems for triage, referral, case monitoring & management; (b) staff development Users rate satisfaction	
	Establish a long-term financial base	Data from financial records	

A Few Related References

New Approaches to Evaluating Community Initiatives -- Concepts, Methods and Contexts. J.P. Connell, A.C. Kubisch, L.B. Schorr, & C.H. Weiss (Eds.). Washington, DC: The Aspen Institute, 1995.

On Understanding Intervention in Psychology and Education. H.S. Adelman & L. Taylor. Westport, CT: Praeger, 1994. See section on "The Evaluation Problem"

Multi-Stage Evaluation for a Community Mental Health System for Change. K. Kutash, A. Duchnowski, M. Johnson, & D. Rugs (1993). *Administration and Policy in Mental Health, 20,* 311-322.

An Interorganizational Network Approach to Evaluating Children's Mental Health Service Systems. J.P. Morrissey (1992). *New Directions for Program Evaluation, 54,* 85-99.

The Process Study Components of Mental Health Evaluation. R.D. Perry, B.H. Hoff, D.S. Gaither (1994). *Evaluation and Program Planning, 17,* 43-46.

What Works for Whom: The Design and Evaluation of Children's Mental Health Services. M. Armstrong, S. Huz, & M. Evans (1992). *Social Work Research & Abstract, 28,* 35-41.

Child and Adolescent Mental Health Services: Evaluation Challenges. L. Bickman & D.J. Rog (1992). *Evaluating Mental Health Services for Children, 54,* 5-16.

Evaluating Children's Mental Health Systems: An analysis of Critical Behaviors and Events. D. Rugs & K. Kutash (1994). *Journal of Child and Family Studies, 3,* 249-262.

Scales to Assess Child and Adolescent Depression: Checklists, Screens and Nets. E.J. Costello & A. Angold (1988). *Journal of American Academic Child and Adolescent Psychiatry, 27,* 726-737.

Structured Interviews for Assessing Children. K. Hodges (1993). *Journal of Child Psychology and Psychiatry, 34,* 49-68.

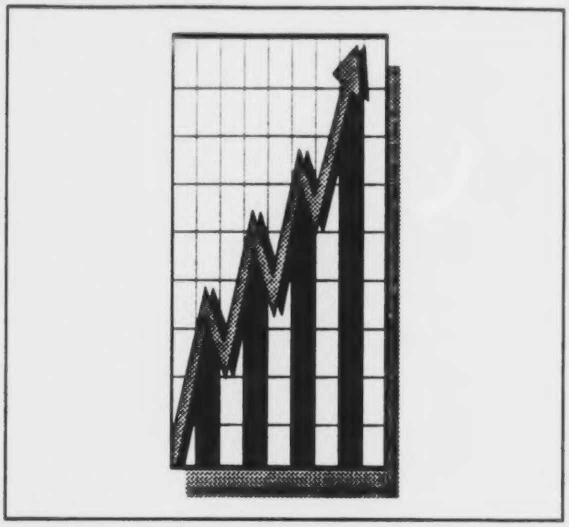
Improving Accountability in a Service Delivery System in Children's Mental Health. J.D. Burchard (1992). *Clinical Psychology Review, 12,* 867-882.

Assessing Mental Health Outcome Measurement Techniques. J.A. Ciarlo, T.R. Brown, D.W. Edwards, T.J. Kiresuk, & F.L. Newman (1986). National Institute of Mental Health. Series FN No. 9. DHHS Pub. No. (ADM) 86-1301. Washington, DC: Supt. of Docs., U.S. Govt. Printing Office.

Assessing Outcomes for Sufferers of Severe Mental Disorder: A Conceptual Framework and Review. A. Rosenblatt & C.C. Attkinsson (1993). *Evaluation and Program Planning, 16,* 3347-363.

Integrating Systems of Care in California for Youth with Severe Emotional Disturbance (Two reports from the California AB377 Evaluation Project). A. Rosenblatt & C.C. Attkinsson (1992). *Journal of Child and Family Studies, 1,* 93-113; 263-286.

Use of Structured Assessment Tools in Clinical Practice. M.D. Weist, & M. Baker. (1995). Paper presented at the 1995 annual meeting of the American Society for Adolescent Psychiatry.



UNIT IIIB: EVALUATING IN STAGES

Contents

Page

- Stage I -- Initial Mental Health Program Development, Implementation, and Evaluation IIIB-3
- Stage II -- Integration with Relevant School Psychosocial Programs & Expansion of Programs, Services, and Evaluation Focus IIIB-5
- Stage III -- Outreach to School District/Community Psychosocial Programs and Further Expansion of Programs, Services, and Evaluation Focus IIIB-7
    >Problem Screening and Analysis IIIB-8
    >Problem Resolution IIIB-9
- Stages IV-VI IIIB-10
    >IV -- Institutionalization of programs and services IIIB-10
    >V -- Short-term follow-up evaluation IIIB-10
    >VI -- Long-term follow-up evaluation IIIB-11

Resource Aids IIIB-12

Exhibits and Resource Aids in Unit IIIB

Exhibits

Unit IIIB *Page*

25. Six Stages in the Development and Evaluation of the Mental Health Focus of School-Based Health Centers IIIB-2

26. Stage I -- Mental Health Program Development & Initial Implementation IIIB-4

27. Stage II -- Integration with Relevant School Psychosocial Programs & Expansion of Programs, Services, and Evaluation Focus IIIB-6

Resource Aids

Unit IIIB

IIIB-1 Daily Log Record IIIB-14

IIIB-2 Consultation Encounter Form IIIB-16

IIIB-3 Consultation Follow-up Data and Feedback Form IIIB-17

IIIB-4 Initial Student Data a SBHC Can Report IIIB-18

IIIB-5. SBHC Student Visit Form (Chart Record) -- Mental Health and and Psychosocial Concerns IIIB-30

IIIB-6 Gathering Data on Clinic Use and Nonuse and Needs Assessment IIIB-35

IIIB-7 A Flowchart of a 52 Week Evaluation Process IIIB-36

UNIT IIIB
EVALUATING IN STAGES

Just as a School-Based Health Center needs to develop its mental health focus in phases, there is a neeed to develop evaluation in stages (see Exhibit 25).

> For new and evolving large-scale interventions, the first stages of evaluation must be formative and stress the type of *research and development* activity that produces a sound program. Thus, in these early stages, evaluation procedures must be extremely broad and embody the dynamic, spiraling quality of evaluative *research* (see references at end of the module). To this end, the evaluation activity must be programmatic, with the initial emphasis broadly focused on improving intervention processes (e.g., clarifying the nature and soundness of the intervention rationale, procedures, intended outcomes, and immediate accomplishments).

As the initial stages are accomplished and a program is operating properly, the emphasis moves to an in-depth focus on validating interventions in terms of specific efficacy. To this end, in-depth sampling becomes a viable strategy for studying intervention efficacy. At these later stages of evaluation, data from other programs and from settings without such programs provide important comparison information for arriving at evaluative judgments.

Exhibit 25. Six Stages in the Development and Evaluation of the Mental Health Focus of School-Based Health Centers

Stage I:

Initial mental health program development, implementation, and evaluation

Stage II:

Integration with relevant school psychosocial programs and expansion of programs, services, and evaluation focus

Stage III:

Outreach to school district/community psychosocial programs and further expansion of programs, services, and evaluation focus

Stage IV:

Institutionalization of mental health programs, services, and evaluation

Stage V:

Short-term follow-up evaluation of programs and service outcomes

Stage VI:

Long-term follow-up evaluation of programs and service outcomes

STAGE I --Initial Mental Health Program Development, Implementation, and Evaluation

This stage essentially involves describing what is happening. For example, significant amounts of time must be spent initially

- identifying and recruiting students in need
- evolving existing programs
- developing new programs
- finding useful referral resources
- establishing case management procedures and linkages with school programs

and so forth.

All this activity should be described along with clarification of the number of students who have contacted the center primarily for help with psychosocial problems, the types of psychosocial problems seen, and the number of direct encounters and referrals of students/parents (see Exhibit 26).

Other important matters to be documented include initial activity related to

- mental health education (e.g., presentations to classes designed to prevent/minimize psychosocial problems)

- consultations with center staff and school personnel about specific students or general types of problems

- nonstudent presentations at school and in the community

- networking.

Exhibit 26. Stage I – Mental Health Program Development & Initial Implementation

Examples of Information that Can Be Gathered	*Information Gathering Procedures*
PROGRAMS INITIATED AND STUDENTS SERVED	
summaries of specific programs (e.g., recruitment, direct intervention, referral, mental health education, etc.)	program descriptions
tallies of students/parents • interviews/assessments • counseling (ind./grp./family) • case management • referrals • crisis intervention	daily log records (see Resource Aid IIIB-1)
summaries of students' problems, motivation for help, prognosis, and progress	needs assessment process description of how specific students are identified self-reports & intervener ratings at intake, during visits, & at termination and follow-up (see Resource Aid IIIB-2) chart record of problem (see Resource Aid IIIB-5)
INITIAL OUTREACH tallies • consultations • nonstudent presentations (school/comm.)	daily log records
INITIAL RESOURCE IDENTIFICATION AND DEVELOPMENT	
tallies & summary descriptions of specific activities (e.g., activity related to establishing appropriate referral resources)	daily log records process descriptions product descriptions (e.g., referral system files, resource handouts)
INITIAL NETWORKING tallies & summary description of specific activities (e.g., meetings, workshops, etc)	daily log records process descriptions product descriptions

STAGE II -- Integration with Relevant School Psychosocial Programs & Expansion of Programs, Services, and Evaluation Focus

In addition to continuing with the evaluation procedures developed in Stage I, activity at Stage II involves describing the ways the mental health focus of the center is integrated with other center activity and with other school-based psychosocial programs (see Exhibit 27).

With respect to the center itself, it is especially important to document how the center's mental health professionals work with the

- medical staff
- health educator
- other mental health personnel
- clerical staff

With respect to the other psychosocial programs at the school, the need is to document how the center's mental health focus is coordinated with such programs and the degree to which the center has stimulated efforts to expand the range of psychosocial programs and services available at the school.

Also, at this stage, it is appropriate to describe the systems that have been developed for reporting center status, activity, accomplishments, and ongoing needs and concerns.

Exhibit 27. Stage II – Integration with Relevant School Psychosocial Programs & Expansion of Programs, Services, and Evaluation Focus

Examples of Information that Can Be Gathered	*Information Gathering Procedures*
ALL INFORMATION LISTED FOR STAGE I	(See preceding Exhibit)
INTEGRATION WITHIN THE CENTER	
summaries of mental health staff roles and functions vis a vis working with other center staff (e.g., triage functions, treatment teaming, health education teaming, consultation, training, program development)	program and job descriptions
tallies on specific activity	daily log records
INTEGRATION OF CENTER WITHIN SCHOOL	
summaries of mental health staff roles and functions vis a vis working with school staff (e.g., triage functions, treatment teaming, health education teaming, consultation, training, program development)	program and job descriptions
tallies on specific activity	daily log records
REPORTING SYSTEMS	
summaries of mental health staff roles and functions vis a vis developing, implementing, and maintaining reporting systems (e.g., staffing patterns, job protocols)	program and job descriptions
tallies on specific activity	daily log records

421

STAGE III --Outreach to School District/Community PsychosocialPrograms and Further Expansion of Programs, Services, and Evaluation Focus

The objectives at this stage are as follows:

- Document outreach and expansion

  This simply involves continuing to log each activity (see Resource Aid IIIB-1).

- Evaluate center use and clarify reasons given by nonusers

  In effect, a needs assessment can be done each year by sampling center clients and nonenrolled students (see Resource Aid IIIB-4). Such data also can be used as a regular indicator of the center's current level of acceptance and impact on students.

- Choose one problem (e.g., sexual abuse) for indepth evaluation and use it to develop a comprehensive set of formative and summative evaluative procedures that can later be used with respect to other problems.

  > The idea behind choosing one problem for indepth evaluation is that the center cannot do a comprehensive evaluation on every client and every problem. Thus, efforts to obtain comprehensive data should focus on students identified with one specific problem. These data can then be presented, along with the type of general descriptive data already discussed, to provide a reasonable picture of the center's mental health activity. See the discussion on the following pages for more details on this approach. After an adequate in-depth picture of the chosen problem is available, the focus of subsequent, comprehensive data gathering can be shifted to provide an in-depth picture of center activity with respect to another problem (e.g., suicide/depression).

- Analyze evaluative data

  The analysis should bring together data on intervention

  >antecedents (e.g., prognostic and baseline status)
  >transactions (e.g., resources available for planning, implementation, and evaluation)
  >outcomes (e.g., subsequent status)

  in order to arrive at reasonable judgments regarding program efficacy. At this stage, any data available from other centers can be used as another basis for comparison.

422

In doing an in-depth evaluation of one problem, data gathering begins when the problem is first identified, and the intent is to document (1) problem screening and analysis (including first level screening, the analysis of the problem, and indicators of prognosis) and (2) problem resolution (including referral and course of treatment).

Problem Screening and Analysis

First Level Screening

> The information students initially provide when filling out registration and screening forms may be sufficient to identify whether a client has the specific problem that is currently designated for in-depth evaluation. (In this regard, it is important to pay appropriate attention to psychosocial concerns in designing these surveys.) Moreover, analysis of these data will clarify how often first level screens are sufficient for identifying students' primary psychosocial problems. These data also provide the bases for evaluating what subsequent assessment activity contributes to intervention decision making.

Problem analysis and prognosis

Data gathered might include:

(a) Student's analysis of problem, initial causes, current status of problem and factors that must be overcome to correct the problem, motivation for help, and expectancy for successful outcome (see Resource Aid IIIB-2)

(b) Intervener's analysis of the problem, initial causes, current status of problem and factors to be overcome to correct the problem, and prognosis (see Resource Aids IIIB-2 and 3)

If feasible,

(c) Research-oriented data might be gathered to increase understanding of the general nature of such a problem and how it might be ameliorated

Problem Resolution

Referral

The types of information that might be documented with respect to referral processes include:

(a) Availability of resources
(b) Client attitude about referral
(c) Referral intervention
(d) Referral follow-through

Course of Treatment

The types of information that might be documented with respect to the course of treatment include:

(a) Focus of counseling
(b) General nature of processes
(c) Intended outcomes
(d) Actual outcomes at end of counseling (including reason for termination)
(e) Recommendations for future action
(f) Status at short-term follow-up (once this stage is accomplished)
(g) Status at long-term follow-up (once this stage is accomplished)

STAGES IV-VI

IV – Institutionalization of programs and services

The main objective at this stage is to document that the center is owned by the school district (e.g., is financially supported by the district, is included in long-term planning).

V – Short-term follow-up evaluation

During Stage III, a form of follow-up data is gathered when processes are established for yearly evaluation of center use and for clarifying reasons given for nonuse. (The data from the students sampled by these processes also provide an ongoing needs assessment -- see Resource Aid IIIB-4).

Follow-up data on status in the period immediately after assessment, referral, and/or treatment provides essential information to improve procedures and to provide students with additional help if necessary. In addition, such data provide additional outcome information to supplement that gathered at the end of a specific intervention.

At this stage, retrospective evaluations of processes and outcomes can be gathered by a follow-up questionnaire sent to each client at a given period of time (e.g., 3-4 weeks) after the last contact (see Resource Aid 2). In addition, with respect to students identified with the specific problem being evaluated in-depth, all or a subsample could be asked to retake a modified version of the survey (current status/needs assessment) filled out at intake. Also, where feasible, an independent check of school records could be used to compare school attendance pre and post treatment, and teacher and parent ratings could be solicited asking for a comparison of pre and post treatment functioning.

VI – Long-term follow-up evaluation

Given the necessary resources, follow-up data on status over the long-run should be gathered yearly (to minimize attrition due to loss of mail contact). To minimize costs, the focus should be on subsamples representing specific problems evaluated in-depth. An abbreviated version of the survey (current status/needs assessment) filled out at the short-term follow-up should suffice.

Resource Aid IIIB-7 includes a flow chart of a 52 week evaluation process, offers examples of program objectives, and describes eight threats to internal validity. (The focus is on a drug abuse treatment program, but you will find the material readily adaptable to evaluating a range of psychosocial and mental health concerns.)

RESOURCE AIDS

A. Resource Aids Included Here

Appendix III-1

Quality Assurance and Documenting Program Effectivenes

This appendix provides excerpts from critical issues planning sessions conducted by the Center for Mental Health Assistance (University of Maryland at Baltimore)

Resource Aid IIIB-1

Daily Log Record

Provides an example of a simple checklist form designed to record the variety of mental health related activities carried out by each SBHC staff member.

Example of Forms to Record and Evaluate NonDirect Service Activity

Forms used to record and evaluate consultation are included here to illustrate how to get credit for all you do.

Resource Aid IIIB-2

Consultation Encounter Form

A simple way to keep trach of consultation activity.

Resource Aid IIIB-3

Consultation Follow-Up Data and Feedback Form

A Rating form for feedback.

Resource Aid IIIB-4

Student Data

All initial interview and evaluation follow-up forms and records should be designed to accumulate student self-reports and intervener ratings. The type of computer-linked student registration and encounter forms many centers already have adopted provide an example of a good meshing of clinical and evaluation-relevant data. This Resource Aid lists some of the data that might be gathered and presents a few examples of clinical interview forms to provide additional illustrations of efforts to include evaluation-relevant data in clinical procedures.

Resource Aid IIIB-5

SBHC Standard Visit Form (Chart Record) -- Mental Health and Psychosocial Concerns

Provides an example of a checklist format for chart recording that can be easily coded for computer use..

Resource Aid IIIB-6

Clinic Use and Nonuse and Needs Assessment

An illustration of the types of (a) group contrasts/ comparisons that can be made and (b) concerns for which specific questions might be formulated.

Resource Aid IIIB-7

A Flowchart of a 52 Week Evaluation Process

As a guide to evaluation, this Aid illustrates activity over a 1 year period, provides examples of program objectives and describes threats to internal validity. The focus is on a drug abuse treatment program, but the material is readily adaptable to evaluating a range of psychosocial and mental health concerns.

Resource Aid IIIB-1

Daily Log Record

Student ID# or Name of Activity	Mental Health Intervention						Outreach				Development of Resources		Other (e.g. meetings)
	Exploration with student/ parent about need	Initial Intervention	Short Term		Case Coord.	Ref.	Consultation with staff		Presentations		on camp	off camp	
			Ind.	Grp.			school	clinic	on camp	off camp			

Sample of How Data Might Be Reported

OVERALL RECORD OF ACTIVITY FOR 1st 6 MONTHS OF OPERATION

		Number of Encounters
1. Direct Intervention		
a. Informal exploration about help		411
b. Initial interviews		64
c. Short-term counseling	(Ind.)	365
	(grp.)	33
d. Case coordination		0
e. Referral		1

Beyond informal explorations about help, the overall number of client encounters recorded by the clinic is 1870. (Consent forms have been turned in by 480 students; 376 have used the clinic.) Thus, to date, 25% of the 1870 client encounters have been with the mental health component. (This represents 65 of the 376 students who have used the clinic.)

	Number of Encounters
2. Outreach	
a. Consultation	
with school personnel	206
with clinic staff	148
b. Presentations	20
3. Resource Development	
a. Evolving programs on campus	4
b. Information on community resources	64
4. Networking (e.g., meetings)	71

CONSULTATION ENCOUNTER FORM

Consultant______________ Date__________

Consulted with: Teacher___________________

Principal________ Other (specify)___________

Type of consultation: exploration of general concerns _____

problem solving session _____

facilitating resource networking _____

others specify)____________________

If focus was on a specific student, who? _____________________

Is this student a (school-based health center) client? Y N

Others involved in the process (specify)__________________________

BRIEFLY:

What was the nature of the problem(s)?

What actions, if any, were planned to deal with the problem(s)?

What are the next steps and who is responsible for taking them?

Resource Aid IIIB-3

CONSULTATION FOLLOW-UP DATA AND FEEDBACK RATINGS

Consultant______________ Date__________

School_________________ Consulted with:________________________________

1. Please rate the severity of the problem prior to consultation.

1	2	3	4
Very severe	Severe	Not too severe	Not at all severe

2. Did the consultation lead to implementation of additional strategies for solving the problem?

YES NO

3. Has the situation improved? YES NO

4. Please rate the current severity of the problem.

1	2	3	4
Very severe	Severe	Not too severe	Not at all severe

5. Do you want additional consultation on this problem? YES NO

6. How worthwhile do feel it was for you to have worked with the consultant?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	quite a bit	very much

7. How much did the consultation help you to better understand the problem?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	quite a bit	very much

8. How much did the consultation help you deal with the problem in a better way?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	quite a bit	very much

9. If you need similar help in the future, how likely are you to seek consultation?

1	2	3	4
Not at all likely	Not too likely	Likely	Definitely will

Initial Student Data that a SBHC Can Report

Even in the initial stages of evaluation, a center might minimally focus on the following:

*factors that may interfere with successful intervention (e.g., frequent absences, school or legal probation, substance abuse, gang involvement, deficiencies related to intervention resources)

*status of psychosocial problems at initial contact (e.g., types, pervasiveness, severity, chronicity, apparent cause)

*initial motivation for help as rated by student and intervener,

*student expectation of overcoming the problem to be worked on and the intervener's rating of prognosis,

*progress rated periodically by student and intervener,

*additional problems noted as contact continues,

*status at termination as rated by student and intervener,

*status at follow-up.

The following forms (also included in a preceding unit) represent one set of aids in gathering such data. You will find data gathered using others forms included in this guidebook also are useful. And school records provide another readily available source. A brief example of how such data can be summarized in table form also is included here.

Student's View of the Problem -- Initial Interview Form
(For use with all but very young students)

Interviewer ______________________ Date______________

Note the identified problem

Is the student seeking help? Yes No

If not, what were the circumstances that brought the student to the interview?

________________________________ _________________________

Questions for student to answer

Student's Name ______________________________ Age _____ Birthdate ___________

Sex M F Grade ________ Current Placement ______________________

Ethnicity __________ Primary Language ____________________

We are concerned about how things are going for you. Our talk today will help us to discuss what's going O.K. and what's not going so well. If you want me to keep what we talk about secret, I will do so -- except for those things that I need to discuss with others in order to help you.

(1) How would you describe your current situation? What problems are you experiencing? What are your main concerns?

(2) How serious are these matters for you at this time?

1 2 3 4
very serious Not too Not at
serious serious all serious

(3) How long have these been problems?

___ 0-3 months ___4 months to a year ____more than a year

(cont.)

(4) What do you think originally caused these problems?

(5) Do others (parents, teachers, friends) think there were other causes?
If so, what they say they were?

(6) What other things are currently making it hard to deal with the problems?

(7) What have you already tried in order to deal with the problems?

(8) Why do you think these things didn't work?

(9) What have others advised you to do?

(10) What do you think would help solve the problems?

(11) How much time and effort do you want to put into solving the problems?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	quite a bit	very much

If you answered 1, 2, or 3, why don't you want to put much time and effort into solving problems?

(12) What type of help do you want?

(13) What changes are you hoping for?

(14) How hopeful are you about solving the problems?

1	2	3	4
very hopeful	somewhat	not too	not at all hopeful

If you're not hopeful, why not?

(15) What else should we know so that we can help?

Are there any other matters you want to discuss?

Student's View of the Problem -- Initial Interview Form

(For use with very young students)

Interviewer ______________________ Date______________

Note the identified problem:

Is the student seeking help? Yes No

If not, what were the circumstances that brought the student to the interview?

****

Questions for student to answer:

Student's Name ______________________________ Age _____ Birthdate ___________

Sex: M F Grade ________ Current Placement ______________________

Ethnicity __________ Primary Language ____________________

We are concerned about how things are going for you. Our talk today will help us to discuss what's going O.K. and what's not going so well. If you want me to keep what we talk about secret, I will do so -- except for those things that I need to discuss with others in order to help you.

(1) Are you having problems at school? ___Yes ___No
If yes, what's wrong?

What seems to be causing these problems?

(2) How much do you like school?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	Quite a bit	Very much

What about school don't you like?

What can we do to make it better for you?

(3) Are you having problems at home? ___Yes ___No
If yes, what's wrong?

What seems to be causing these problems?

(4) How much do you like things at home?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	Quite a bit	Very much

What about things at home don't you like?

What can we do to make it better for you?

(5) Are you having problems with other kids? ___Yes ___No
If yes, what's wrong?

What seems to be causing these problems?

(6) How much do you like being with other kids?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	Quite a bit	Very much

What about other kids don't you like?

What can we do to make it better for you?

(7) What type of help do you want?

(8) How hopeful are you about solving the problems?

1	2	3	4
very hopeful	somewhat	not too	not at all hopeful

If you're not hopeful, why not?

(9) What else should we know so that we can help?

Are there any other things you want to tell me or talk about?

(cont.)

Sample of How Data Might Be Reported

EXAMPLES OF STUDENTS' VIEWS AT THE BEGINNING OF COUNSELING

OF CAUSE

something they did (30); something others did (38), bad luck (3)

Other life stressors mentioned by student:
school demands; behavior of other students and family members, friend or family member moving away; availability of drugs; worry about future: poor grades; alcoholism in family; preparing for college, pregnant; illness in the family; need a job

WHAT HAS BEEN TRIED IN DEALING WITH PROBLEM

tried to ignore problem; tried to stand up to others; tried suicide; talked to family, talked to friend; talked to counselors/therapists/priests; on medication; get into sports, vitamins, eat more; sleep more; exercise; keep busy; patience; family counseling

WHY DIDN'T IT WORK?

parents won't listen; others don't understand; I didn't try; parents still fight, can't trust others to keep confidences

WHAT DO OTHERS ADVISE?

keep busy; use cocaine; move; talk to your parents; see a therapist or priest; leave your boyfriend; don't be depressed; forget your girlfriend, relax; stay with girlfriend; be strong, eat more; do what she's told; study more

WHAT DO YOU THINK WOULD HELP?

need to change myself (38); need others to change (18); don't know (25)

HOW MUCH TIME AND EFFORT DO YOU WANT TO PUT INTO SOLVING PROBLEMS?

none (0); not much (5); only a little bit (5); more than a little bit (7); quite a bit (22), very much (18)

WHAT TYPE OF HELP DO YOU WANT?

how to relate to parents; someone to reason with anything; someone to talk to my parents, information about alcohol and other drugs; advice; someone to listen; help to forget her help and understanding; medicine; become emancipated relaxation techniques; don't know

WHAT CHANGES ARE YOU HOPING FOR?

to be a better person; to get along; no more problems; make my parents happy; face my problems; more friends; stop drugs; change my attitude; learn to accept; forget her, for things to be easier; get a place to stay; a better life, communication, academic improvement, get a job; less nervous better grades; more self-control; to become somebody; more interest in school

HOW HOPEFUL ABOUT SOLVING THE PROBLEM(S)?

very hopeful (14), somewhat hopeful (39); not too hopeful (5), not at all hopeful (1)

Form Used to Aid Follow-Up on Referral Follow-Through

The following form should be used in conjunction with a general calendar system (a "tickler" system) that alerts staff to students who are due for some follow-up activity

Student's Name ___________________ Today's Date _____

DATES FOR FOLLOW-THROUGH MONITORING

Scheduled date for Immediate Follow up_______ (about 2 weeks after referral)

Scheduled date for Long-term *first* Follow up_______

Schedule for *Subsequent* Long-term Follow ups _______ _______ _______

I. Immediate Referral Follow up Information

Date of referral __________ Today's date_____
Immediate Follow up made by_______________________ Date_________
_______________________ Date_________
_______________________ Date_________

Service Need	Agency (name and address)	Phone	Contact person	Appt. time

A. Put a check mark next to those agencies with which contact was made,
B. Put a line through agencies that didn't work out;
C. Put a circle next to agencies still to be contacted

Indicate any new referrals recommended

Service Need	Agency (name and address)	Phone	Contact person	Appt. time

---

II. Long Term Referral Follow-Up Information

Have identified needs been met?

Contact the student at appropriate intervals (beginning three months after referral) and administer "Follow-up Interview Form -- Service Status "

442

Follow-up Rating Form -- Service Status (Intervener Form)

(To be filled out periodically by ***interveners)***

To: _(Intervener's name)_

From ____________________, Primary Care Manager

Re: Current Status of a client referred to you by ________________ school.

Student's Name or ID # ______________________ Birthdate _______ Date ___________

Number of sessions seen: Ind.___ Group ____

What problems were worked on?

Current status of problems worked on: (Severity at this time)

1	2	3	4
very severe	severe	not too severe	not at all severe

If the problems worked on differ from the "presenting" problems (e.g., referral problem), also indicate the current status of the presenting problems.

1	2	3	4
very severe	severe	not too severe	not at all severe

Recommendations made for further action:

Are the recommendations being followed? YES NO

If no, why not?

How much did the intervention help the student in better understanding his/her problems?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	quite a bit	very much

How much did the intervention help the student to deal with her/his problems in a better way?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	quite a bit	very much

Prognosis

1	2	3	4
very positive	positive	negative	very negative

Follow-up Rating Form -- Service Status **(Client Form)**
(To be filled out periodically by the clients)

Student's Name or ID # ________________________ Birthdate _______ Date____________

1. How worthwhile do you feel it was for you to have worked with the counselor?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	quite a bit	very much

2. How much did the counseling help you better understand your problems?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	quite a bit	very much

3. How much did the counseling help you deal with your problems in a better way?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	quite a bit	very much

4. At this time, how serious are the problems for you?

1	2	3	4
very severe	severe	not too severe	not at all severe

5. How hopeful are you about solving your problems?

1	2	3	4
very hopeful	somewhat hopeful	not too hopeful	not at all hopeful

If not hopeful, why not?

6. If you need help in the future, how likely are you to contact the counselor?

1	2	3	4
not at all	not too likely	likely to	definitely will

Sample of How Data Might Be Reported

CLINICIAN AND STUDENT EVALUATION OF COUNSELING

(Data from interview on status at end of short-term intervention)

Data were available from 16 students who unilaterally initiated termination and 16 who continued in treatment until they and the therapist agreed it was time to end counseling. Data were not available only for a few students

Number of visits

Unilateral termination (Unil.)	1-9 (mode=3)
Agreed upon termination (Agrd.)	1-23 (mode =8)

Ratings	*Clinician* Unil	*Clinician* Agrd	*Student* Unil.	*Student* Agrd
Current status of problem				
very severe				
severe	5		1	
not too severe	8	10	6	9
not at all severe	3	4	8	7
no rating		2	1	
Clinician Prognosis/Student hopefulness				
very positive		5	7	2
positive	12	10	4	6
negative	4		1	4
very negative			2	
no rating		1	2	4
Improved understanding of problems				
not at all				
not much	3		1	
only a little bit	4	1	4	
more than a little bit	7	3	3	
quite a bit	2	7	3	7
very much		4	4	9
no rating		1	1	
Improved ability to deal with problems				
not at all				
not much	4		1	
only a little bit	8	1	6	
more than a little bit	2	6	2	4
quite a bit	2	5	2	6
very much		3	4	6
no rating		1	1	
Student view of worth of counseling				
not at all				
not much			1	
only a little bit			6	
more than a little bit			1	
quite a bit			4	6
very much			3	10
Student statement of likelihood of contacting center if similar help is needed in the future				
not at all			3	
not too likely			1	1
likely			10	9
definitely will			2	6

Resource Aid IIIB-5

SCHOOL-BASED HEALTH CENTER

Standard Visit Form (Chart Record) -- Mental Health & Psychosocial Concerns

Student's Center ID# ____________ Visit Date ___/___/____ Intervener ______________

Consent Form Allows for this service ___ Registration Date: ___/___ ___

Student Name ____ SEX ___ (M/F)
Last First Middle

BIRTHDATE __/__/__ Age:___ Grade ___

Ethnicity:____________________ Primary Language:___________

Presenting Problem for Mental Health services:

Change in status since last visit positive ___ negative ___ no change ___

Clinician's view of Problem:		**Severity** (of prob. or reaction				**Duration** (onset or length)		
		Very Sev.	Sev.	Not too	Not at all	0-3 mos	4 mo. -1 yr.	more than a yr.
I. Emotional State		1	2	3	4			
A. Sad	___	___	___	___	___	___	___	___
B. grief	___	___	___	___	___	___	___	___
C. suicidal thinking	___	___	___	___	___	___	___	___
D. fearful	___	___	___	___	___	___	___	___
E. anxious	___	___	___	___	___	___	___	___
F. low esteem	___	___	___	___	___	___	___	___
G. aggression/ anger	___	___	___	___	___	___	___	___
H. other (specify)								
__________	___	___	___	___	___	___	___	___

***II. Relationship Problems*:**	separation	conflict							
A. family	___	___	___	___	___	___	___	___	___
B. peers	___	___	___	___	___	___	___	___	___
C. close friend	___	___	___	___	___	___	___	___	___
D. teachers	___		___	___	___	___	___	___	___
E. other (specify)									
__________	___		___	___	___	___	___	___	___

Clinician's view of Problem:		**Severity** (of prob. or reaction				**Duration** (onset or length)		
		Very Sev.	Sev.	Not too	Not at all	0-3 mos	4 mo. -1 yr.	more than a yr.
III. School Functioning:		1	2	3	4			
A. trouble adjusting to new school	___	___	___	___	___	___	___	___
B. learning problems	___	___	___	___	___	___	___	___
C. unmotivated at school	___	___	___	___	___	___	___	___
D. behavior problems	___	___	___	___	___	___	___	___
E. considering dropping out	___	___	___	___	___	___	___	___
F. other (specify)								
___________	___	___	___	___	___	___	___	___
IV. Psychological support needed for other problems:								
A. diet (weight loss, anorexia, bulimia)	___	___	___	___	___	___	___	___
B. sexual behavior	___	___	___	___	___	___	___	___
C. pregnancy	___	___	___	___	___	___	___	___
D. assertiveness	___	___	___	___	___	___	___	___
E. somatic complaints	___	___	___	___	___	___	___	___
F. sleep problems	___	___	___	___	___	___	___	___
G. gender concerns	___	___	___	___	___	___	___	___
H. other (specify)								
___________	___	___	___	___	___	___	___	___
V. Abuse/Neglect by others:								
A. physical	___	___	___	___	___	___	___	___
B. sexual	___	___	___	___	___	___	___	___
C. victimization	___	___	___	___	___	___	___	___
D. emotional	___	___	___	___	___	___	___	___
E. neglect	___	___	___	___	___	___	___	___
F. other (specify)								
___________	___	___	___	___	___	___	___	___
VI. Substance Abuse:								
A. drugs	___	___	___	___	___	___	___	___
B. alcohol	___	___	___	___	___	___	___	___
C. other (specify)								
___________	___	___	___	___	___	___	___	___

Clinician's view of Problem		**Severity** (of prob or reaction				**Duration** (onset or length)		
		Very Sev	Sev	Not too	Not at all	0-3 mos	4 mo -1 yr	more than a yr
VII. Transition Problems:		1	2	3	4			
A. change in residence	___	___	___	___	___	___	___	___
B. family changes (e.g., birth, death, separation	___	___	___	___	___	___	___	___
C. changes at school (e.g., new school, new programs)	___	___	___	___	___	___	___	___
D. other (specify) ____________	___	___	___	___	___	___	___	___

VIII. Other: (specify)

Apparent Cause

Intervention Plan	*Individual*	*Group*
Therapy/counseling with Center Mental Health staff	___	___
Work with Center Health Educator	___	___

Other (specify) ____

Impact of the Session Just Conducted

very productive ____ unproductive ____ somewhat productive ___ uncertain ___

Any changes in Intervention Plan (including referrals)?

Sample of How Data Might Be Reported

SUMMARY*

A. SOURCES OF REFERRAL

Of the 2,600 students in the school, 480 have turned in consent forms and 376 have sought treatment at the center. Of the 376, 65 have been referred to the psycho-social component. (During the same period, approximately were referred to school, personnel for help with psycho-social problems.)

Of the 65 seen by the mental health component of the center,

9 came to the center for a sports' physical and were referred for a problem noted on the Teen Health Survey

23 came in for a physical or a physical health problem and were referred for a problem noted on the Teen Health Survey

24 were encouraged to seek such help by school personnel

2 were encouraged to seek such help by peers or relatives

3 came in for a pregnancy test and were referred for related psycho-social counseling

3 came for counseling

1 came for referral to a community service

B. DEMOGRAPHICS

1. Sex

24	males
41	females

2. Age

6	15 years old
29	16 years old
19	17 years old
11	18 years old

3. Grade Level

32	10th
21	11th
12	12th

4. Ethnicity

55	Hispanic
5	Black
3	White
2	Asian (including Filipino, Vietnamese)

*Note: The above data were summarized from an earlier version of the preceding Visit Form (Chart Record)

C. REFERRAL PROBLEMS

Type of Problem	Clinician's View of Primary Problem (N=65)	Student's View of Primary Problem (N=64)
Relationships		
family	12	16
peers	2	2
close friend	1	5
Emotions		
depression	32	15
fears	1	0
anxiety/tension	3	5
low self-esteem	2	0
suicidal	0	2
grief	2	2
Abuse		
physical	0	0
sexual	6	4
victimization	0	0
Substance Abuse	0	4
Academic		
failure	0	3
motivation	2	0
drop out	0	1
Other		
diet	1	0
pregnancy	0	0
assertiveness	0	0
somatic complaints	0	1
sexual identity	1	1
Severity of Problem		
very serious	8	3
serious	46	17
not too serious	11	36
not at all serious	0	4
Duration of Problem		
0-3 months	8	11
4 mos. - 1 year	7	9
more than 1 year	50	40

*Note: The above data were summarized from an earlier version of the preceding Visit Form (Chart Record).

Resource Aid IIIB-6

GATHERING DATA ON CLINIC USE AND NONUSE & NEEDS ASSESSMENT

Group Contrasts/Comparisons

There are four groups to be contrasted with respect to School-Based Health Center use

Group A: center users
Group B: consented infrequent users
Group C: unconsented but aware
Group D: unconsented and unaware

In contrasting these groups, comparisons can be made between students who do and those who do not report

- *significant problems
- *seeking help
- *gang involvement
- *substance involvement

Other comparisons can be made with respect to

- males/females
- year in school/age
- average grades/ number of U's
- race
- religion
- language spoken primarily
- length of time in U S
- parental status
- who student lives with
- parent's work status
- parent's educational level

Concerns of Particular Interest (Some of the following also can be used as a basis for additional subgroup comparisons)

Self-reports of

1. Reasons for not using SBHC -- contrasting Groups B, C, D
2. Reasons for using SBHC -- contrasting Groups A and B
3. Satisfaction with SBHC care -- contrasting Groups A and B
4. Stated likelihood of signing up -- contrasting Groups C and D
5. Psychosocial problems
   - a. in general
   - b. in specific problem areas
   - c. with respect to specific symptom clusters and their frequency/severity (e.g., depression, anxiety, interpersonal sensitivity, somaticization, obsessive-compulsiveness)
   - d. with respect to chronicity
6. Behavioral problems and related concerns
   - a. absences (total; truancies; suspensions, alcohol/drug related)
   - b. kicked out of class
   - c. sent to office
   - d. argued with teacher
   - e. expelled
   - f. fist fights
   - g. run away from home
   - h. arguments with family
   - i. arguments with friends
   - j. substance abuse (alcohol/drugs)
   - k. sexual abuse
   - l. worry about STD
   - m. purging
   - n. police
   - o. gang involvement
   - p. parenthood
   - q. others specific to center

7. Does student see problems as interfering with schoolwork?

8. Has student sought help? why not?
   If yes, specify type, source of help, frequency of help

A questionnaire instrument covering the above matters has been drafted and is to be pilot tested. The draft version is available, upon request, from the School Mental Health Project at UCLA

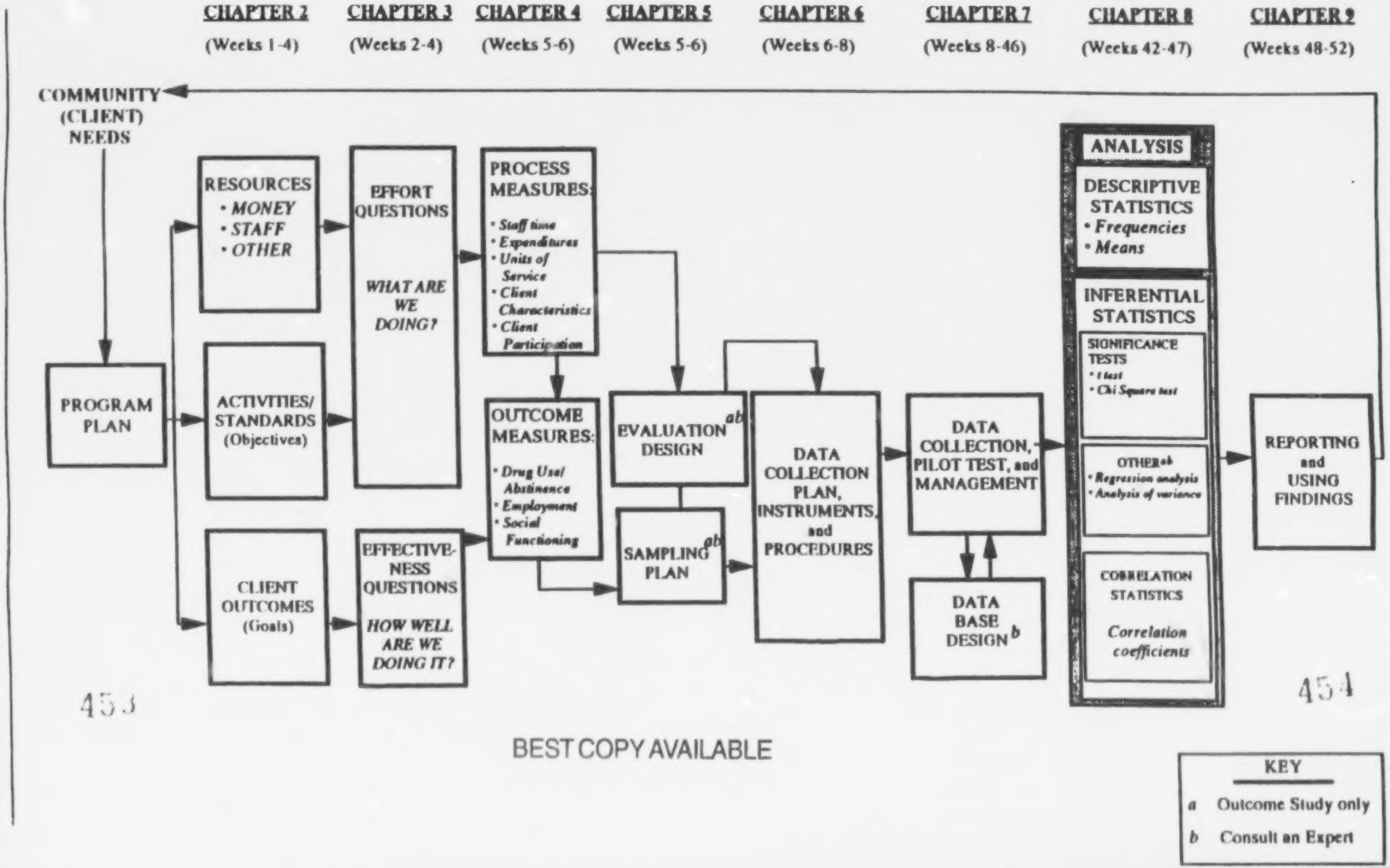
A Flowchart of a 52 Week Evaluation Process

The following material is from a resource published by the National Institute on Drug Abuse (in Rockville, MD).

The work is entitled:

> *How Good is Your Drug Abuse Treatment Program?*
> *A Guide to Evaluation*
>
> Although the work uses drug abuse treatment as its focus, it provides a good illustration of how to plan evaluation activity over a 1 year period, provides examples of program objectives and describes threats to internal validity.

Exhibit 1-3. Flowchart of a 52 Week Evaluation Process



BEST COPY AVAILABLE

Exhibit 2-4: Examples of Program Objectives

Goal: Cygnus clients will develop a lifestyle that supports abstinence and enables them to provide healthy home environments for their children.

Objectives:

(1) Eighty percent of clients, before leaving treatment, will have completed a 6-week employment skills program that covers job search skills, interviewing skills, and basic work skills.

(2) Eighty percent of clients with husbands or significant others, before leaving treatment, will have completed 12 weeks of couples counseling.

(3) Eighty percent of clients will have completed a 6-week parenting skills program of 2 hourly meetings per week before leaving treatment.

(4) Eighty percent of clients will have completed a 3-part workshop on self-esteem within 45 days after entering treatment.

(5) Eighty percent of clients will have completed a relapse prevention program within 6 months of completing primary treatment.

EXHIBIT 5-1: EIGHT THREATS TO INTERNAL VALIDITY

1. HISTORY: Unplanned events that occur between the first and second measurements. Examples include changes in local drug use patterns, drug supply interruptions, changes in treatment approach, and seasonal drug use patterns. In general, the more time that elapses between measurements, the greater the threat from historical effects.

2. MATURATION: Developmental changes that naturally occur in clients. Growing older, more experienced, or more independent may be especially important maturation effects with adolescent client populations. Other maturation effects raise particular concerns in samples from special populations in transition, such as pregnant women, HIV positive clients, and ex-offenders re-entering society from prison.

3. TESTING: Effects of taking a measurement on the results of subsequent measurement. Repeated urine tests for drug use tend to discourage later drug use, for example, while repeated ability tests tend to raise scores as subjects practice their test-taking skills, even if no real increase in ability occurs.

4. INSTRUMENTATION: Effects of changes in a measurement instrument, or in criteria for recording behavior, during the course of an evaluation. Common examples are a change in the cutoff point for a "drug positive" determination by a urinalysis laboratory or a change in police criteria for making arrests (for example, during a neighborhood crackdown).

5. STATISTICAL REGRESSION: Effects of selecting samples on the basis of extreme behavior—over time, their behavior tends to "regress" toward the overall group average. In drug treatment program evaluation, prodrug attitudes in an extremely prodrug sample, heroin consumption in a sample selected during periods of heavy use, and self-esteem in a sample selected on the basis of low self-esteem, will all tend to be less extreme on a second measurement.

6. SELECTION: Effects of unmeasured difficulties between a group receiving treatment and a nonequivalent group not receiving treatment. Common examples of unmeasured difficulties include clients' motivation to seek treatment, family and social support structures, and expectations about future drug use. The problem tends to arise when treatment is given to volunteers and withheld from nonvolunteers, instead of assigning volunteers randomly to treatment.

7. ATTRITION: Effects of unequal dropout rates among different subgroups in the sample. In drug treatment program evaluation, common examples include differences between those who receive treatment and those who do not, between heavier drug users and lighter users, or between more and less satisfied clients.

8. HAWTHORNE EFFECT: Effect of changes which are due to the fact of being included in an evaluation.

Appendix III-1

Excerpts on:

Quality Assurance and Documenting Program Effectiveness

from:

Critical Issue Planning Sessions Conducted by the
Center for School Mental Health Assistance
(University of Maryland at Baltimore)

On: *Quality Assurance and Documenting Program Effectiveness*

Excerpts from:
Critical Issue Planning Sessions Conducted by the Center for
School Mental Health Assistance (University of Maryland at Baltimore)

As part of its work, our sister center at the University of Maryland at Baltimore (directed by Mark Weist) convenes analysis and planning sessions with national experts. The following are some excerpts of relevance to the topics of quality assurance and documenting program effectiveness at SBHCs.

Quality Assurance. A few points endorsed by the quality assurance discussion group

(1) Major dimensions of Quality Assurance (QA) are
- Access and Availability
- the Quality of Interventions
- Continuity of Care
- Collaboration between Providers
- Acceptability of Services to Consumers
- Reasonable Cost

(2) To ensure quality, SMH [school mental health] services should be integrated with community health services and reflect genuinely collaborative relationships between mental health, health, and educational staff.

(3) There is an important distinctions between Quality Assurance (QA) and Quality Improvement (QI). QI is a gradual and progressive improvement in the process of care toward meeting long-term objectives., while QA is more of a snapshot of how an organization is functioning at a given point in time. QI never ends.

(4) Efforts to document the effectiveness of SMH programs are actually subsumed under QI. ... The benefits of SMH services must be connected to outcomes pertaining to educational functioning. Efforts to document the cost savings and general community benefits (e.g., in assisting the juvenile justice system) of these programs are also critically needed.

(5) The degree to which SMH programs address pressing problems in their surrounding communities (e.g., teenage pregnancy, violence) is an important dimension for measuring their quality. ...

(6) Ideally, SMH programs should emphasize primary and secondary prevention of psychosocial adjustment problems in youth. There [also] will be a need for tertiary preventive services; ... the needs of youth with severe/chronic disturbances cannot be neglected. [In this last respect], SMH programs should not replicate other services in communities but be meshed with them.

(7) To truly have an impact, SMH programs need to be accepted by school staff and the teachers' union. One method to promote such acceptance is to highlight the benefits of SMH programs in "enabling" children's learning .... This connection is absolutely critical to political advocacy efforts for SMH services.

(8) Families need to be closely involved in all phases and aspects of planning for and providing SMH programs. Outreach efforts to families, while often frustrating, are critically important.

In enumerating indices of quality, the group focused mainly on clinical services. As indicated throughout this unit, obviously quality indices are needed for the whole range of SBHC efforts to help the school address student needs. The indices generated by the group are:

- amount of time between referral of students and contact with clinicians
- appointment keeping rate of referred students
- percentage of referred students who are actually seen by the clinician
- number of students who are successfully referred to appropriate services in the community (e.g., for medication)
- amount of services provided (e.g., number o students seen; number of individual, group and family therapy sessions)
- degree of family involvement (e.g., percentage of students seen with contact between the clinician and the family)
- educational and emotional/behavioral improvement in youth from pre to post intervention
- "consumer satisfaction" ratings from youth, families and educational staff
- number or percentage of youth referred for special education services
- number or percentage of youth who undergo changes in intensity of special education services (e.g., from higher to lower)
- having an orientation program for new clinicians
- "sensitivity" of mental health providers to factors important to the school setting
- functioning of multidisciplinary teams (e.g., disciplines represented, yearly objectives accomplished)
- degree to which mental health staff become accepted by, and part of, the school milieu
- amount of appropriate (e.g., by licensed providers) clinical supervision of the school-based therapist
- expertise and experience of school-based clinicians
- support provided to the SMH program by the school administration (e.g., adequacy of office space)
- compliance of the program with relevant state laws and professional guidelines

In concluding, the group suggested four "overarching goals" for SMH programs: (1) provide comprehensive direct clinical assessment and treatment services for underserved youth, (2) emphasize preventive programs that provide early identification and treatment for youth in need, (3) ensure that mental health programs have a strength or competency focus, versus an exclusive focus on reducing psychopathology, and (4) seek to maximize the impact of mental health services by involvement in collaborative efforts aimed at improving the global school environment

Documenting the Effectiveness of School Mental Health Programs. The following are excerpts of points endorsed by the group brought together specifically to discuss this topic

Important Factors to Consider in Developing SMH Evaluations

Principles that characterize good SMH evaluation programs. These principles include

- Being relevant to the type of services provided and the population served,
- having an evaluation process that would be generalizable to different programs and different student populations,
- viewing evaluation as an ongoing process, which provides feedback to efforts to continuously improve services,
- attending to cultural sensitivity in evaluation processes and measures.
- involving key "stakeholders" in the evaluation process, such as students, families, school staff, and funders,
- including multiple levels of assessment, for example, measuring student grades and absenteeism, as well as satisfaction of teachers with the program,
- being relatively simple and "doable,"
- focusing on factors that are likely to be affected by the program, and
- using measures that are "face valid," or make sense to those completing them.

Student-Focused Evaluation Programs

Student characteristics and indices of functioning that are most relevant to SMH programs

- Commonly occurring "emotional" problems such as depression, anxiety, traumatization symptoms, and social withdrawal,
- commonly occurring behavioral problems such as aggression, oppositionality, classroom disruptiveness, and hyperactivity,
- school performance in terms of grades, scores on standardized tests, attendance, and discipline problems,
- family and peer relationships, and
- competencies or qualities of "resilience" such as social skills, positive self-concept, involvement in meaningful activities, participation in athletics, spirituality, coping skills and problem-solving

There was discussion of the fact that frequently in mental health, there is a bias toward focusing on pathology, and that positive qualities of youth are often neglected in evaluation process There was strong support for a focus on competency variables in SMH program evaluations

Ethics of SMH Evaluations

Discussion emphasized the following points

- Parental consent for services is essential
- Family members should be involved in the development of SMH services, and should provide feedback on them once they are developed
- There is an ethical requirement to provide treatment when screening programs are initiated. As such, programs should be cautious about implementing broad screening projects if they have limited resources to provide follow-up services
- Special safeguards are necessary to protect the confidentiality of students receiving SMH services (e.g., the fact that they are receiving mental health services can usually be witnessed by other students)
- Programs need to document that youth are receiving enough from a program to justify an intensive evaluation
- When professional staff are not involved in the collection of data, protections need to be in place to ensure its confidentiality
- Whenever possible, programs should use reliable and valid measurement tools, versus created ones, to avoid the possibility of anomalous findings

Additional Caveats

Pitfalls of evaluation and problems that are encountered in evaluation efforts include

- The psychotherapy outcome literature has failed to document that interventions as commonly implemented in applied settings are actually effective. When an SMH evaluation yields negative results, this information can and should be used to improve the program. However, there is a danger that if such negative results are disseminated, they could be used to justify a cut in funding
- Many youth show up for mental health appointments in schools during crises. Overtime, these youth would do better without intervention. As such, we need to be careful to ascribe recovery from a crisis to SMH services
- In some SMH programs, clinicians are so overwhelmed with students in need, that less than optimal services are able to be delivered to any one student. This dilutes the effect of school-based interventions, and may lead to failure of evaluations to document positive changes
- A common failure in evaluation programs is the failure to assess the integrity of treatment services. For example, in many programs little is known about the skill level of the therapist, and what happens behind the therapy door. In structured programs to address particular student problems (e.g., anger control), clinicians have been shown to deviate from the prescribed treatment program without structure (e.g., treatment manuals) and ongoing monitoring of their performance
- As a general rule, SMH programs are not fine-tuned interventions, which decreases the likelihood of finding positive impacts
- Many of the instruments used in child mental health assessment basically provide information on whether the child does or does not meet criteria for a specific problem (i.e., "caseness"). These measures are commonly not sensitive to treatment effects. Similarly, there is a lot of random movement from "case" to "noncase" and caution is needed in ascribing this movement to an SMH program

The above points highlight complexities and difficult issues involved in SMH evaluation, particularly evaluations focused on treatment outcomes. As such, programs should be cautious in attempting to document treatment impacts. However, assessment of treatment outcomes is only one aspect of evaluation

Desired Outcomes for SMH Programs for Relevant Stakeholders

What needs to be demonstrated for SMH programs to expand? Desired outcomes are enumerated for each of four groups of SMH program stakeholders: (1) children and families, (2) schools, (3) community health and mental health systems, and (4) funders.

Children and Families

- academic success
- enhanced self-esteem
- improved social skills
- improved capacity to function independently
- more positive behaviors at home and school
- decreased levels of emotional disturbance

Schools

- academic success
- improved school attendance
- reduced school violence and aggression
- established linkages between the child and other needed services

Community Health/Mental Health System

- detection and treatment of emotional/behavioral problems early
- prevention of emotional and behavioral problems
- family preservation
- decreased child abuse
- decreased suicidal behavior in youth
- decreased substance abuse by youth
- fewer entries into the juvenile justice system

Funders

- reduction of high cost services such as hospitalization

Five Important Outcomes that cut across stakeholder groups.

- Prevention of emotional/behavioral problems and early intervention to prevent their worsening,
- improved school attendance,
- decreased risk-taking behavior including substance abuse and violence by youth,
- decreased use of high intensity services, including community health services such as hospitalization, and school services such as placement in special education, and
- improved collaborative linkages for programs within schools, and between school-based and community-based programs.

(Note: Group participants emphasized that reduction of emotional/behavioral symptoms in youth per se, is not a priority outcome; rather, positive changes in these symptoms should impact youth functioning in other domains as above. Thus, symptom reduction should be viewed as a means to an end, versus and end in and of itself.)

A Few Other Comments

- The design and conduct of treatment outcome studies are highly complex and fraught with problems. These problems include the general failure of the few existing studies to document significant benefits, the considerable variability that occurs in service delivery not only across, but within programs, and the generally limited resources of SMH programs to mount these kinds of studies. In essence, most SMH programs should be interested in evaluating the *effectiveness of programs*, not in evaluating the *efficacy of particular treatments*.

- In designing SMH programs, there is a need to analyze how the school-based program will affect the community. For example, a program could reduce school violence by expelling violent students, but this would likely cause problems in the community. In SMH evaluations, there needs to be attention to positive *and* potentially negative community impacts.

- If SMH programs strive to target "resilience factors," or variables that have been shown in the literature to promote positive psychosocial adjustment in youth under stress (e.g., family support, social skills, involvement in meaningful activities), the likelihood that these programs will show positive and meaningful impacts should be improved.

- There is a continuum of SMH programs in terms of their sophistication and resources available to them. "Cadillac" programs will have a much greater chance of documenting program benefits than smaller, more isolated programs. In essence, program planners should consider the "minimum threshold for evaluation" to avoid the worst case scenario of evaluating a small program, finding negative results, and then losing funding. Generally, [it is] recommended that comprehensive evaluations only be conducted for programs (i.e., not one part-time clinician in one school), that preferably have some institutional backing (e.g., from a university or community health/mental health agency).

- Evaluation should be tailored to the size and nature of the SMH program. Small programs should emphasize evaluation of the impacts for individual children, and should not undertake systems evaluations, as systems level changes will probably not be shown. Systems level evaluations should be limited to larger programs with more resources. Essentially, SMH programs should conduct a "self-evaluation process," to guide decisions about the appropriate evaluation strategy.

- One problem that has severely constrained SMH program evaluation has been the lack of funding to do this. . . . Clearly, such funding is needed to document program strengths and weaknesses. Lobbying efforts will be important to sell funders on the benefits of, and significant need for SMH program evaluation.

A Recommended Process for SMH Program Evaluation

1. Define the program (e.g., number of clinicians, funding, provided services).
2. Define stakeholders for the program and determine their interests and goals.
3. Develop program goals so that they reflect interests of stakeholders.
4. Develop a *realistic* evaluation plan, focusing on outcomes that are of interest to stakeholders, and that can be collected within the pragmatic constraints of the program.
5. Gain feedback from the stakeholders on the evaluation plan and modify the plan based on this feedback.
6. Implement the evaluation plan and monitor its implementation.
7. Organize program evaluation findings.
8. Present program evaluation findings to representative stakeholders for their feedback and input.
9. Modify and improve the program based on results of the evaluation.

MENTAL HEALTH AND SCHOOL-BASED HEALTH CENTERS

Coda:

Comprehensive Approaches & Mental Health in Schools

So persuasive is the power of the institutions we
have created that they shape not only our preferences,
but actually our sense of possibilities.
Ivan Illich

To address the needs of troubling and troubled youth, schools tend to overrely on narrowly focused and time intensive interventions. Given sparse resources, this means serving a small proportion of the many students who require assistance and doing so in a limited way. The deficiencies of prevailing approaches lead to calls for comprehensiveness -- both to better address the needs of those served and to serve greater numbers.

Comprehensiveness and Mental Health in Schools
Comprehensive School-Based Health Centers
Comprehensive School Health
Toward a Comprehensive, Integrated Approach

Comprehensiveness and Mental Health in Schools

Comprehensiveness is becoming a buzzword. Health providers pursue comprehensive systems of care; states establish initiatives for comprehensive school-linked services; school-based clinics aspire to become comprehensive health centers, and there is talk of comprehensive school health programs. Widespread use of the term masks the fact that comprehension is a vision for the future -- not a reality of the day.

Comprehensiveness requires developmental and holistic perspectives that are translated into an extensive continuum of programs focused on individuals, families, and the environment. Such a continuum ranges from primary prevention and early-age intervention -- through approaches for treating problems soon after onset -- to treatment for severe and chronic problems. Included are programs designed to promote and maintain safety at home and at school, programs to promote and maintain physical and mental health, preschool and early school adjustment programs, programs to improve and augment ongoing social and academic supports, programs to intervene prior to referral, and programs providing intensive treatment. This scope of activity underscores why mechanisms for ongoing interprogram collaboration are essential.

Schools are the focus of several initiatives aspiring to comprehensiveness. Key examples are (1) moves toward school-based health centers and full service schools and (2) the model for comprehensive school health.

Comprehensive School-Based Health Centers

Many of the over 1,000 school-based or linked health clinics are described as comprehensive centers. This reflects the fact that a large number of students want not only the medical services, but help with personal adjustment and peer/family relationship problems, emotional distress, problems related to physical and sexual abuse, and concerns stemming from use of alcohol and other drugs. Indeed, data indicate that up to 50% of clinic visits are for nonmedical concerns. Given the limited number of staff at such clinics, it is not surprising that the demand for psychosocial and mental health interventions quickly outstrips available resources. School-based and linked health clinics can provide only a restricted range of interventions to a limited number of students. Thus, the desire of such clinics to be comprehensive centers in the full sense of the term remains thwarted.

Joy Dryfoos encompasses the trend to develop school-based health clinics, youth service programs, community schools, and other similar activity under the rubric *of full service schools*. To date, the reality of this desire for comprehensiveness remains mostly a vision. And, as long as the vision is anchored in the school-linked services model (i.e., initiatives to restructure community health and human services), it is likely that resources will remain too limited to allow for a comprehensive continuum of programs.

Comprehensive School Health

Up until the 1980s, school health programs were seen as encompassing health education, health services, and health environments. Over the last decade, an eight component model for a comprehensive focus on health in schools has been advocated. The components are: (1) health education, (2) health services, (3) biophysical and psychosocial environments, (4) counseling, psychological, and social services, (5) integrated efforts of schools and communities to improve health, (6) food service, (7) physical education and physical activity, and (8) health programs for staff.

To develop each states' capacity to move toward comprehensive school health programming, the Centers for Disease Control and Prevention (CDC) set in motion an initiative designed to increase state-level interagency coordination. Relatedly, the Educational Development Center with funding from CDC is in the midst of a project to clarify how national organizations and state and local education and health agencies can advance school health programs.

The focus on comprehensive school health is admirable. It is not, of course, a comprehensive approach for addressing a full range of barriers interfering with learning -- nor does it profess to be. Unfortunately, it's restricted emphasis on health tends to engender resistance from school policy makers who do not understand how they can afford a comprehen-sive focus on health and still accomplish their primary mission to educate students. Reform-minded policy makers may be more open to proposals encompassing a broad range of programs to enhance healthy development if such programs are part of a comprehensive approach for addressing barriers to learning.

With respect to addressing barriers to learning, comprehensiveness requires more than *outreach to* link with *community* resources, more than *coordination* of *school-owned* services, and more than *coordination* of *school and community* services. Moving toward comprehensiveness encompasses restructuring and enhancing

(1) school-owned programs and services and

(2) community resources,

and in the process, it is essential to

(3) weave school and community resources together.

The result is not simply a reallocation or relocation of resources; it is a total *transformation* of the approach to intervention.

Toward a Comprehensive, Integrated Approach

Policy makers and reformers have not come to grips with the realities of addressing barriers to learning and fostering healthy development. A few preliminary steps have been taken toward reform, such as more flexibility in the use of categorical funds and waivers from regulatory restrictions. There also is renewed interest in cross-disciplinary and interprofessional collaboration training programs.

As our Center's 1996 policy report stresses, however:

> *For school reform to produce desired student outcomes, school and community reformers must expand their vision beyond restructuring instructional and management functions and recognize that there is a third primary and essential set of functions involved in enabling teaching and learning.*

The essential third facet of school and community restructuring encompasses integration of enabling programs and services with instructional and management components. For a cohesive "enabling component" to emerge requires (a) weaving together school-owned resources and (b) enhancing programs by integrating school and community resources (including increasing access to community programs and services by linking as many as feasible to programs at the school). This comprehensive, integrated approach is meant to *transform* how communities and their schools address barriers to learning and enhance healthy development.

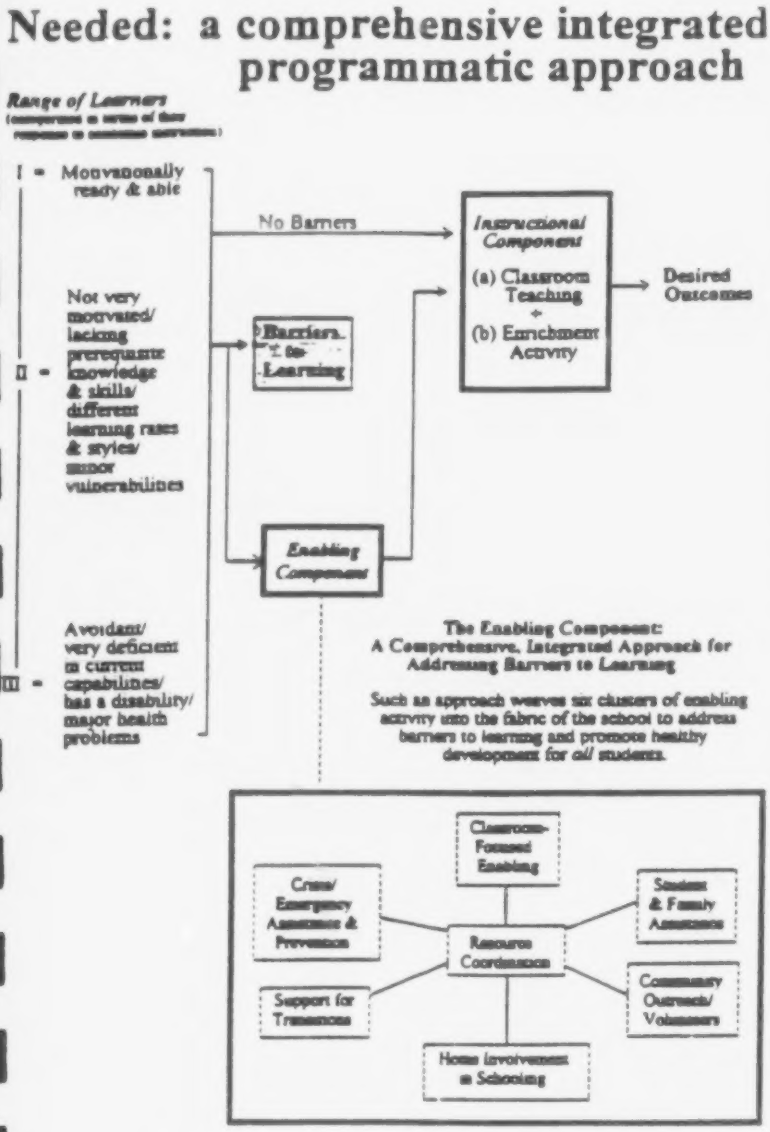
The concept of an enabling component provides a unifying focus around which to formulate new policy. Adoption of an inclusive unifying concept is seen as pivotal in convincing policy makers to move to a position that recognizes enabling activity as essential if schools are to attain their goals.

Operationalizing an enabling component requires formulating a carefully delimited framework of basic programmatic areas and creating an infrastructure for restructuring enabling activity. Based on analyses of extant school and community activity, enabling activity can be clustered into six basic programmatic areas that address barriers to learning and enhance healthy development (all of which includes a focus on mental health).

The six areas encompass interventions to

- enhance classroom-based efforts to enable learning
- provide prescribed student and family assistance
- respond to and prevent crises
- support transitions
- increase home involvement in schooling
- outreach for greater community involvement and support -- including recruitment of volunteers

The following diagram highlights the rationale for and nature of an enabling component.


Needed: a comprehensive integrated programmatic approach
Range of Learners
I = Motivationally ready & able
No Barriers
Instructional Component
(a) Classroom Teaching
+
(b) Enrichment Activity
Desired Outcomes
Not very motivated/ lacking prerequisite knowledge & skills/ different learning rates & styles/ minor vulnerabilities
II =
Barriers to Learning
Enabling Component
Avoidant/ very deficient in current capabilities/ has a disability/ major health problems
III =
The Enabling Component:
A Comprehensive, Integrated Approach for Addressing Barriers to Learning
Such an approach weaves six clusters of enabling activity into the fabric of the school to address barriers to learning and promote healthy development for all students.
Classroom-Focused Enabling
Crisis/ Emergency Assistance & Prevention
Student & Family Assistance
Resource Coordination
Support for Transitions
Community Outreach/ Volunteers
Home Involvement in Schooling

To clarify each area a bit

(1) Classroom focused enabling. In this area, the idea is to enhance classroom-based efforts to enable learning and productive classroom functioning by increasing teacher effectiveness for preventing and handling problems. This is done by providing personalized professional develop-ment and enhanced resources to expand a teacher's array of strategies for working with a wider range of individual differences. For example, teachers learn to use peer tutoring and volunteers (as well as home involvement) to enhance social and academic support, they learn to increase their accommodative strategies and their ability to teach students compensatory strategies, and as appropriate, they are provided support in the classroom by resource teachers and counselors. Only when necessary is temporary out of class help provided. In addition, programs are directed at developing the capabilities of aides, volunteers, and any others helping in classrooms or working with teachers to enable learning. To further prevent learning, behavior, emotional, and health problems, there is also an effort to enhance facets of classroom curricula designed to foster socio-emotional and physical development.

(2) Student and family assistance. Some problems cannot be handled without a few special interventions; thus the need for student and family assistance. The emphasis is on providing ancillary services in a personalized way to assist with a broad-range of needs. To begin with, available social, physical and mental health programs in the school and community are used. As community outreach brings in other resources, they are linked to existing activity in an integrated manner. Particular attention is paid to enhancing systems for prereferral intervention, triage, case and resource management, direct services to meet immediate needs, and referral for special services and special education resources and placements as appropriate. Ongoing efforts are made to expand and enhance resources.

(3) Crisis assistance and prevention. The intent is to respond to, minimize the impact of, and prevent crises. This requires systems and

BEST COPY AVAILABLE

programs for emergency/crisis response at a site, throughout a school complex, and community-wide (including a program to ensure follow-up care), it also encompasses prevention programs for school and community to address school safety and violence reduction, suicide, child abuse, and so forth. Crisis assistance includes ensuring immediate emergency and follow-up care is provided so students are able to resume learning without undue delay. Prevention activity creates a safe and productive environment and develops the type of attitudes and capacities that students and their families need to deal with violence and other threats to safety.

(4) *Support for transitions.* This area involves a programmatic focus on the many transition concerns confronting students and their families. Such efforts aim at reducing alienation and increasing positive attitudes and involvement related to school and various learning activities. Examples of interventions include (a) programs to establish a welcoming and socially supportive school community, especially for new arrivals, (b) counseling and articulation programs to support grade-to-grade and school-to-school transitions, moving to and from special education, going to college, moving to post school living and work, and (c) programs for before and after-school and intersession to enrich learning and provide recreation in a safe environment.

(5) Home involvement in schooling. Efforts to enhance home involvement must range from programs to address specific learning and support needs of adults in the home to approaches that empower sanctioned parent representatives to become full partners in governance. Examples include (a) programs to address adult learning and support needs, such as ESL classes and mutual support groups, (b) helping those in the home meet their basic obligations to the student, such as programs on parenting and helping with schoolwork, (c) systems to improve communication about matters essential to student and family, (d) programs to enhance the home-school connection and sense of community, (e) interventions to enhance participation in decisions essential to the student, (f) programs to enhance home support for student's basic learning and development, (g) interventions to mobilize those at home to problem solve related to student needs, and (h) intervention to elicit help (support, collaborations, and partnerships) from those at home in order to meet classroom, school, and community needs. The context for some of this activity may be a *parent center* (which may be part of a *Family Service Center* facility if one has been established at the site).

(6) Community outreach for involvement and support (including a focus on volunteers). Outreach to the community is used to build linkages and collaborations, develop greater involvement in schooling, and enhance support for efforts to enable learning. Outreach is made to public and private community agencies, universities, colleges, organizations, and facilities; businesses and professional organizations and groups, and volunteer service programs, organizations, and clubs. Examples of activity include (a) programs to recruit community involvement and support (e.g., linkages and integration with community health and social services; volunteers, mentors, and individuals with expertise and resources; local businesses to adopt-a-school and provide resources, awards, incentives, and jobs; formal partnership arrangements), (b) systems and programs designed to train, screen, and maintain volunteer parents, college students, senior citizens, peer and cross-age tutors and counselors, and professionals-in-training who then provide direct help for staff and students -- especially targeted students, (c) programs outreaching to hard to involve students and families (those who don't come to school regularly -- including truants and dropouts), and (d) programs to enhance community-school connections and sense of community (e.g., orientations, open houses, performances and cultural and sports events, festivals and celebrations, workshops and fairs).

Ultimately, a comprehensive set of programs to address barriers and enhance healthy development must be woven into the fabric of every school. In addition, feeder schools need to link together to maximize use of limited school and community resources. By working to develop a comprehensive, integrated approach, every school can be seen, once more, as a key element of its community. When schools are seen as a valued and integrated part of every community, talk of school and community as separate entities can cease, talk of education as if it were the sole function of schools should end, and the major role schools can play in enhancing healthy development may be appreciated.

Encompassing the Concept of Comprehensive School Health into a Comprehensive Approach to Address Barriers to Student Learning

It has been our experience that schools respond better when proposals emphasize *a comprehensive approach to addressing barriers to learning*, rather than recommending a focus on specifically on physical and mental health. Given the thrust to enhance *Comprehensive School Health* in general and the eight "component" Comprehensive School Health model in particular, it is important to understand that the concept of the Enabling Component readily encompasses the eight components of comprehensive school health. That is, these eight components fit readily into the six areas of the Enabling Component with some of the eight components best understood as fitting more than one cluster of Enabling Component programming (see the Exhibit on the next page.)

Some Relevant References

Adelman, H.S. (1996). *Restructuring support services: Toward a comprehensive approach.* Kent, OH: American School Health Association.

Adelman, H.S. (1996). Restructuring education support services and integrating community resources: Beyond the full service school model. *School Psychology Review, 25,* 431-445.

Adelman, H.S. & Taylor, L. (1997). Addressing barriers to learning: Beyond school-linked services and full service schools. *American Journal of Orthopsychiatry, 67,* 408-421.

Dryfoos, J.G. (1994). *Full-service schools: A revolution in health and social services for children, youth, and families.* San Francisco: Jossey-Bass.

Knapp, M.S. (1995). How shall we study comprehensive collaborative services for children and families? *Educational Researcher, 24,* 5-16.

Kolbe, L. (1993). An essential strategy to improve the health and education of Americans. *Preventive Medicine, 22,* 544-560.

Taylor, L., & Adelman, H.S. (1996). Mental health in the schools: Promising directions for practice. *Adolescent Medicine: State of the Art Reviews, 7,* 303-317.

GLOSSARY OF KEY TERMS, ACRONYMS, AND LAWS

Those interested in psychosocial and mental health concerns encounter a host of specialized terms, acronyms, and references to legislation. On the following pages, you will find a brief resource aid and references to the sources from which they were drawn should you want to pursue more extensive glossaries.

Included here are:

Excerpts from:

American Psychiatric Glossary (seventh edition; 1994)
published by the American Psychiatric Press (Washington, DC)

a glossary of acronyms and laws related to emotional and behavior disorders compiled by the Institute for Adolescents with Behavioral Disorders, Arden Hills, MN

Also included is a copy of

Children's and Adolescents' Mental Health: A Glossary of Terms
prepared and circulated by the U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services

Some Key Terms Related to Mental Health and Psychosocial Problems

The following is a sampling of key terms from the American Psychiatric Glossary (7th edition, edited by Jane Edgerton and Robert Campbell, III [1994]. Washington, DC American Psychiatric Press, Inc.). It provides a user-friendly definition for quick referral. For a more extensive listing of terms, see the original source.

abnormality In psychological terms, any mental, emotional, or behavioral activity that deviates from culturally or scientifically accepted norms.

abreaction Emotional release or discharge after recalling a painful experience that has been repressed because it was not consciously tolerable (see *conscious)*. A therapeutic effect sometimes occurs through partial or repeated discharge of the painful *affect*. See also *systematic desensitization*.

academic disorders In DSM-IV, this is a major group of *infancy, childhood, and adolescence disorders* that includes *reading disorder, mathematics disorder*, and disorder of *written expression*.

acculturation difficulty A problem in adapting to or finding an appropriate way to adapt to a different culture or environment. The problem is not based on any coexisting *mental disorder*.

acting out Expressions of *unconscious* emotional conflicts or feelings in actions rather than words. The person is not consciously aware of the meaning of such acts (see *conscious)*. Acting out may be harmful or, in controlled situations, therapeutic (e.g., children's play therapy).

adaptation Fitting one's behavior to meet the needs of one's environment, which often involves a modification of impulses, emotions, or attitudes.

adjustment Often transitory functional alteration or accommodation by which one can better adapt oneself to the immediate environment and to one's inner self. See also *adaptation*.

adjustment disorder An imprecise term referring to emotional or behavioral *symptoms* that develop in response to an identifiable stressor. The symptoms, which may include *anxiety*, depressed mood, and disturbance of conduct, are clinically significant in that the distress exceeds what would be expected under the circumstances, or significant impairment in social or occupational functioning is produced. Duration of symptoms tends to be self-limited, not persisting more than 6 months after termination of the stressor or its consequences. Sometimes the disorder is designated as "acute" if duration is 6 months or less, and as "persistent" or "chronic" if symptoms endure beyond 6 months.

affect Behavior that expresses a subjectively experienced feeling state *(emotion)*; affect is responsive to changing emotional states, whereas mood refers to a pervasive and sustained emotion. Common affects are euphoria, anger, and sadness. Some types of affect disturbance are

blunted Severe reduction in the intensity of affective expression.

flat Absence or near absence of any signs of affective expression such as a monotonous voice and an immobile face.

inappropriate Discordance of voice and movements with the content of the person's speech or ideation.

labile Abnormal variability, with repeated, rapid, and abrupt shifts in affective expression.

restricted or constricted Reduction in the expressive range and intensity of affects.

affective disorder A disorder in which mood change or disturbance is the primary manifestation. Now referred to as *mood disorder*. See *depression*.

aggression Forceful physical, verbal, or symbolic action May be appropriate and self-protective, including healthy self-assertiveness, or inappropriate as in hostile or destructive behavior May also be directed toward the environment, toward another person or *personality*, or toward the self, as *in depression*.

agitation Excessive motor activity, usually nonpurposeful and associated with internal tension Examples include inability to sit still, fidgeting, pacing, wringing of hands, and pulling of clothes See *psychomotor agitation*.

agoraphobia *Anxiety* about being in places or situations in which escape might be difficult or embarrassing or in which help may not be available should a *panic attack* occur The fears typically relate to venturing into the open, of leaving the familiar setting of one's home, or of being in a crowd, standing in line, or traveling in a car or train Although agoraphobia usually occurs as a part of *panic disorder*, agoraphobia without a history of panic disorder has been described

Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) An agency in the U.S. Department of Health and Human Services that was replaced in 1992 by the Substance Abuse and Mental Health Services Administration (SAMHSA). In reorganizing ADAMHA into SAMHSA, the three ADAMHA research institutes, the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the National institute on Drug Abuse (NIDA), and the National Institute of Mental Health (NIMH), were moved to the *National Institutes of Health*. What remain in SAMHSA are the substance abuse and mental health services programs.

alcohol use disorders In DSM-IV, this group includes alcohol dependence, alcohol abuse, alcohol intoxication, alcohol withdrawal, alcohol delirium, alcohol persisting dementia, alcohol persisting amnestic disorder, alcohol psychotic disorder, alcohol mood disorder, alcohol anxiety disorder, alcohol sleep disorder, and alcohol sexual dysfunction. See *abuse, substance; dependence, substance; intoxication, alcohol; withdrawal symptoms, alcohol*.

ambivalence The coexistence of contradictory emotions, attitudes, ideas, or desires with respect to a particular person, object, or situation Ordinarily, the ambivalence is not fully *conscious* and suggests psychopathology only when present in an extreme form.

amphetamine use disorders In DSM-IV, this group includes amphetamine (or related substance) dependence, amphetamine abuse, amphetamine intoxication, amphetamine withdrawal, amphetamine delirium, amphetamine psychotic disorder, amphetamine mood disorder, amphetamine anxiety disorder, amphetamine sexual dysfunction, and amphetamine sleep disorder

androgyny A combination of male and female characteristics in one person.

anhedonia Inability to experience pleasure from activities that usually produce pleasurable feelings Contrast with *hedonism*.

anniversary reaction An emotional response to a previous event occurring at the same time of year Often the event involved a loss and the reaction involves a *depressed* state The reaction can range from mild to severe and may occur at any time after the event.

anomie Apathy, alienation, and personal distress resulting from the loss of goals previously valued Emile Durkheim popularized this term when he listed it as a principal reason for *suicide*.

anorexia nervosa An *eating disorder* characterized by refusal or inability to maintain minimum normal weight for age and height combined with intense fear of gaining weight, denial of the seriousness of current low weight, undue influence of body weight or shape on self-evaluation, and, in females, amenorrhea or failure to menstruate Weight is typically 15% or more below normal, and it may decrease to life-threatening extremes In the restricting subtype, the person does not engage regularly in binge eating In the binge eating/purging, or bulimic, subtype, the person engages in recurrent episodes of *binge eating* or purging during the episode of anorexia nervosa See also *bulimia nervosa*.

Antabuse (disulfiram) A drug used in treatment of *alcohol dependence to* create an aversive response to alcohol It blocks the normal metabolism of alcohol and produces increased blood concentrations of acetaldehyde that induce distressing *symptoms* such as flushing of the skin, pounding of the heart, shortness of breath, nausea, and vomiting With more severe reactions, hypertension, cardiovascular collapse, and, sometimes, convulsions may occur

antisocial behavior Conduct indicating indifference to another's person or property, criminal behavior, dishonesty, or abuse are examples. In DSM-IV, childhood or adolescent antisocial behavior and adult antisocial behavior (in contrast to antisocial personality disorder, etc.) are included as "other conditions that may be a focus of clinical attention."

anxiety Apprehension, tension, or uneasiness from anticipation of danger, the source of which is largely unknown or unrecognized. Primarily of *intrapsychic* origin, in distinction to *fear*, which is the emotional response to a consciously recognized and usually external threat or danger. May be regarded as pathologic when it interferes with effectiveness in living, achievement of desired goals or satisfaction, or reasonable emotional comfort.

anxiety disorders In DSM-IV, this category includes panic disorder without agoraphobia, panic disorder with agoraphobia, agoraphobia without history of panic disorder, specific (simple) phobia, social phobia (social anxiety disorder), obsessive-compulsive disorder, posttraumatic stress disorder, acute stress disorder, generalized anxiety disorder (includes overanxious disorder of childhood), anxiety disorder due to a general medical condition, and substance-induced anxiety disorder. (The inclusion of mixed anxiety-depressive disorder into this category awaits further study.) See *agoraphobia; generalized anxiety disorder; mixed anxiety-depressive disorder; obsessive-compulsive disorder; panic disorder; phobia; posttraumatic stress disorder.*

Asperger's disorder A disorder of development characterized by gross and sustained impairment in social interaction and restricted, repetitive, and stereotyped patterns of behavior, interests, and activities occurring in the context of preserved cognitive and language development.

attachment disorder, reactive A disorder of infancy or early childhood, beginning before the child is 5 years old, characterized by markedly disturbed and developmentally inappropriate social relatedness. In the inhibited type of reactive attachment disorder, failure to respond predominates, and responses are hypervigilant, avoidant, or highly ambivalent and contradictory. *Frozen watchfulness* maybe present. In the disinhibited type, indiscriminate sociability is characteristic, such as excessive familiarity with relative strangers or lack of selectivity in choice of attachment figures. The majority of children who develop this disorder (either type) are from a setting in which care has been grossly pathogenic. Either the caregivers have continually disregarded the child's basic physical and emotional needs, or repeated changes of the primary caregiver have prevented the formation of stable attachments.

attention-deficit/hyperactivity disorder (ADHD) A child whose inattention and hyperactivity-impulsivity cause problems may have this disorder. *Symptoms* appear before the age of 7 years and are inconsistent with the subject's developmental level and severe enough to impair social or academic functioning.

In the predominantly inattentive type, characteristic symptoms include distractibility, difficulty in sustaining attention or following through on instructions in the absence of close supervision, avoidance of tasks that require sustained mental effort, failure to pay close attention to details in schoolwork or other activities, difficulty in organizing activities, not listening to what is being said to him or her, loss of things that are necessary for assignments, and forgetfulness in daily activities.

In the predominantly hyperactive-impulsive type, characteristic symptoms are that the person inappropriately leaves his or her seat in classroom or runs about, fidgets or squirms, has difficulty in engaging in leisure activities quietly, has difficulty in awaiting turn in games, and blurts out answers to questions before they are completed. The two types may be combined.

autistic disorder A disorder of development consisting of gross and sustained impairment in social interaction and communication; restricted and stereotyped patterns of behavior, interest, and activities; and abnormal development prior to age 3 manifested by delays or abnormal functioning in social development, language communication, or play. Specific *symptoms* may include impaired awareness of others, lack of social or emotional reciprocity, failure to develop peer relationships appropriate to developmental level, delay or absence of spoken language and abnormal nonverbal communication, stereotyped and repetitive language, idiosyncratic language, impaired imaginative play, insistence on sameness (e.g., nonfunctional routines or rituals), and stereotyped and repetitive motor mannerisms.

aversion therapy A *behavior therapy* procedure in which associated with undesirable behavior are paired with a painful or unpleasant stimulus, resulting in the suppression of the undesirable behavior

biofeedback The use of instrumentation to provide information (i.e. feedback) about variations in one or more of the subject's own physiological processes not ordinarily perceived (e.g., brain wave activity, muscle tension, blood pressure). Such feedback over a period of time can help the subject learn to control certain physiological processes even though he or she is unable to articulate how the learning was achieved.

bipolar disorders In DSM-IV, a group of *mood disorders* that includes bipolar disorder, single episode; bipolar disorder, recurrent; and *cyclothymic disorder*.

A bipolar disorder includes a manic episode at some time during its course. In any particular patient, the bipolar disorder may take the form of a single manic episode (rare), or it may consist of recurrent episodes that are either manic or depressive in nature (but at least one must have been predominantly manic).

bisexuality Originally a concept of *Freud*, indicating a belief that components of both sexes could be found in each person. Today the term is often used to refer to persons who are capable of achieving orgasm with a partner of either sex. See also *gender role*; *homosexuality*.

blocking A sudden obstruction or interruption in spontaneous flow of thinking or speaking, perceived as an absence or deprivation of thought.

bonding The unity of two people whose identities are significantly affected by their mutual interactions. Bonding often refers to the an attachment between a mother and her child.

brief psychotherapy Any form of *psycbotberapy* whose end point is defined either in terms of the number of sessions (generally not more than 15) or in terms of specified objectives; usually goal-oriented, circumscribed, active, focused, and directed toward a specific problem or *symptom*.

bulimia nervosa An *eating disorder* characterized by recurrent episodes of *binge eating* followed by compensatory behavior such as purging (i.e., self-induced vomiting or the use of diuretics and laxatives) or other methods to control weight (e.g., strict dieting, fasting, or vigorous exercise)

burnout A stress reaction developing in persons working in an area of unrelenting occupational demands. *Symptoms* include impaired work performance, fatigue, *insomnia*, *depression*, increased susceptibility to physical illness, and reliance on alcohol or other drugs of abuse for temporary relief

catatonia Immobility with muscular rigidity or inflexibility and at times excitability. See also *schizophrenia*.

catharsis The healthful (therapeutic) release of ideas through "talking out" *conscious* material accompanied by an appropriate emotional reaction. Also, the release into awareness of repressed ("forgotten") material from the *unconscious*. See also *repression*.

character disorder (character neurosis) A *personality disorder* manifested by a chronic, habitual, maladaptive pattern of reaction that is relatively inflexible, limits the optimal use of potentialities, and often provokes the responses from the environment that the person wants to avoid. In contrast to symptoms of *neurosis*, character traits are typically *ego-syntonic*.

clanging A type of thinking in which the sound of a word, rather than its meaning, gives the direction to subsequent associations. Punning and rhyming may substitute for logic, and language may become increasingly a senseless *compulsion* to associate and decreasingly a vehicle for communication. For example, in response to the statement "That will probably remain a mystery," a patient said, "History is one of my strong points."

cluster suicides Multiple *suicides*, usually among adolescents, in a circumscribed period of time and area. Thought to have an element of contagion.

cocaine use disorders In DSM-IV, this group includes cocaine dependence, cocaine abuse, cocaine intoxication, cocaine withdrawal, cocaine delirium, cocaine psychotic disorder with delusions or hallucinations, cocaine mood disorder, cocaine anxiety disorder, cocaine sexual dysfunction, and cocaine sleep disorder

codependency A popular term referring to all the effects that people who are dependent on alcohol or other substances have on those around them, including the attempts of those people to affect the dependent person. The term implies that codependence is a psychiatric disorder and hypothesizes that the family's actions tend to perpetuate (enable) the person's dependence. Empirical studies, however, support a stress and coping model for explanation of the family behavior.

cognitive Refers to the mental process of comprehension, judgment, memory, and reasoning, in contrast to emotional and volitional processes. Contrast with conative.

cognitive-behavioral psychotherapy Cognitive therapy, a short-term psychotherapy directed at specific target conditions or *symptoms*. (*Depression* has been the most intensively investigated to date.) The symptoms themselves are clues to the patient's verbal thoughts, images, and assumptions that account for both the symptomatic state and the psychological vulnerability to that state. Initial treatment is aimed at symptom reduction. The patient is taught to recognize the negative cognitions that contribute significantly to the development or maintenance of symptoms and to evaluate and modify such thinking patterns. The second phase of treatment concerns the underlying problem.

comorbidity The simultaneous appearance of two or more illnesses, such as the co-occurrence of *schizophrenia* and substance abuse or of *alcohol dependence and depression*. The association may reflect a causal relationship between one disorder and another or an underlying vulnerability to both disorders. Also, the appearance of the illnesses may be unrelated to any common etiology or vulnerability.

compensation A *defense mechanism*, operating unconsciously (see un*conscious)*, by which one attempts to make up for real or fancied deficiencies. Also a *conscious* process in which one tries to make up for real or imagined defects of physique, performance skills, or psychological attributes. The two types frequently merge. See also *Adler; individual psychology; overcompensation.*

complex A group of associated ideas having a common, strong emotional tone. These ideas are largely *unconscious* and significantly influence attitudes and associations. See also *Oedipus complex.*

compulsion Repetitive ritualistic behavior such as hand washing or ordering or a mental act such as praying or repeating words silently that aims to prevent or reduce distress or prevent some dreaded event or situation. The person feels driven to perform such actions in response to an *obsession* or according to rules that must be applied rigidly, even though the behaviors are recognized to be excessive or unreasonable.

conduct disorder A *disruptive behavior disorder* of childhood characterized by repetitive and persistent violation of the rights of others or of age-appropriate social norms or rules. *Symptoms* may include bullying others, truancy or work absences, staying out at night despite parental prohibition before the age of 13, using alcohol or other substances before the age of 13, breaking into another's house or car, firesetting with the intent of causing serious damage, physical cruelty to people or animals, stealing, or use more than once of a weapon that could cause harm to others (e.g., brick, broken bottle, or gun).

conversion disorder One of the *somatoform disorders* (but in some classifications called a *dissociative disorder)*, characterized by a *symptom* suggestive of a neurologic disorder that affects sensation or voluntary motor function. The symptom is not consciously or intentionally produced, it cannot be explained fully by any known *general medical condition*, and it is severe enough to impair functioning or require medical attention. Commonly seen symptoms are blindness, double vision, deafness, impaired coordination, paralysis, and seizures.

coping mechanisms Ways of adjusting to environmental stress without altering one's goals or purposes, includes both *conscious and unconscious* mechanisms.

coprophagia Eating of filth or feces.

counterphobia Deliberately seeking out and exposing oneself to, rather than avoiding, the object or situation that is consciously or unconsciously feared.

countertransference The therapist's emotional reactions to the patient that are based on the therapist's *unconscious* needs and conflicts, as distinguished from his or her *conscious* responses to the patient's behavior. Countertransference may interfere with the therapist's ability to understand the patient and may adversely affect the therapeutic technique. Currently, there is emphasis on the positive aspects of countertransference and its use as a guide to a more empathic understanding of the patient.

crack Freebase or alkaloidal *cocaine* that is named for the cracking sound it makes when heated. Also known as "rock" for its crystallized appearance. It is ingested by inhalation of vapors produced by heating the "rock."

cyclothymic disorder In DSM-IV, one of the *bipolar disorders* characterized by numerous hypomanic episodes and frequent periods of depressed mood or loss of interest or pleasure. These episodes do not meet the criteria for a full manic episode or major depressive disorder.

decompensation The deterioration of existing defenses (see *defense mechanism*), leading to an exacerbation of pathological behavior.

defense mechanism *Unconscious* intrapsychic processes serving to provide relief from emotional *conflict and anxiety*. *Conscious* efforts are frequently made for the same reasons, but true defense mechanisms are unconscious. Some of the common defense mechanisms defined in this glossary are *compensation, conversion, denial, displacement, dissociation, idealization, identification, incorporation, introjection, projection, rationalization, reaction formation, regression, sublimation, substitution, symbolization, and undoing.*

delusion A false belief based on an incorrect inference about external reality and firmly sustained despite clear evidence to the contrary. The belief is not part of a cultural tradition such as an article of religious faith. Among the more frequently reported delusions are the following:

delusion of control The belief that one's feelings, impulses, thoughts, or actions are not one's own but have been imposed by some external force.

grandiose delusion An exaggerated belief of one's importance, power, knowledge, or identity.

nihilisitic delusion A conviction of nonexistence of the self, part of the self, or others, or of the world. "I no longer have a brain" is an example.

persecutory delusion The conviction that one (or a group or institution close to one) is being harassed, attacked, persecuted, or conspired against.

somatic delusion A false belief involving the functioning of one's body, such as the conviction of a postmenopausal woman that she is pregnant, or a person's conviction that his nose is misshapen and ugly when there is nothing wrong with it.

denial A *defense mechanism*, operating unconsciously, used to resolve emotional *conflict* and allay *anxiety* by disavowing thoughts, feelings, wishes, needs, or external reality factors that are consciously intolerable.

depersonalization Feelings of unreality or strangeness concerning either the environment, the self, or both. This is characteristic of *depersonalization disorder* and may also occur in *schizotypal personality disorder, schizophrenia,* and in those persons experiencing overwhelming anxiety, stress, or fatigue.

depression When used to describe a mood, depression refers to feelings of sadness, despair, and discouragement. As such, depression may be a normal feeling state. The overt manifestations are highly variable and may be *culture specific*. Depression may be a *symptom* seen in a variety of mental or physical disorders, a *syndrome* of associated symptoms secondary to an underlying disorder, or a specific *mental disorder*. Slowed thinking, decreased pleasure, decreased purposeful physical activity, guilt and hopelessness, and disorders of eating and sleeping may be seen in the depressive syndrome. DSM-IV classifies depression by severity, recurrence, and association with *hypomania or mania*. Other categorizations divide depression into reactive and endogenous depressions on the basis of precipitants or symptom clusters. Depression in children may be indicated by refusal to go to school, *anxiety*, excessive reaction to separation from parental figures, antisocial behavior, and somatic complaints.

disruptive behavior disorder A disturbance of conduct severe enough to produce significant impairment in social, occupational, or academic functioning because of *symptoms* that range from oppositional defiant to moderate and severe conduct disturbances

oppositional defiant symptoms may include losing temper, arguing with adults and actively refusing their requests; deliberately annoying others, blaming others for one's mistakes, being easily annoyed, resentful, or spiteful, and physically fighting with other members of the household.

conduct disturbance (moderate) symptoms may include truancy or work absences, alcohol or other substance use before the age of 13, stealing with confrontation, destruction of others' property, firesetting with intent of causing serious damage, initiating fights outside of home, and being physically cruel to animals.

conduct disturbance (severe) symptoms may include running away from home overnight at least twice, breaking into another's property, being physically cruel to people, stealing with confrontation, repeatedly using a dangerous weapon, and forcing someone into sexual activity

dissociation The splitting off of clusters of mental contents from *conscious* awareness, a mechanism central to hysterical conversion and *dissociative disorder;* the separation of an idea from its emotional significance and affect as seen in the inappropriate *affect* of schizophrenic patients

dysphoria Unpleasant mood.

dysthymic disorder One of the *depressive disorders*, characterized by a chronic course (i.e., seldom without symptoms) with lowered mood tone and a range of other symptoms that may include feelings of inadequacy, loss of self-esteem, or self-deprecation; feelings of hopelessness or despair; feelings of *guilt*, brooding about past events, or self-pity; low energy and chronic tiredness; being less active or talkative than usual; poor concentration and indecisiveness; and inability to enjoy pleasurable activities.

eating disorder Marked disturbance in eating behavior. In DSM-IV, this category includes *anorexia nervosa, bulimia nervosa*, and eating disorder not otherwise specified.

echolalia Parrot-like repetition of overheard words or fragments of speech. It may be part of a developmental disorder, a neurologic disorder, or *schizophrenia*. Echolalia tends to be repetitive and persistent and is often uttered with a mocking, mumbling, or staccato intonation.

encopresis, functional An elimination disorder in a child who is at least 4 years of age, consisting of repeated passage of feces into inappropriate places (clothing, floor, etc.) and not due to a *general medical condition*.

enuresis, functional An elimination disorder in a child who is at least 5 years of age, consisting of repeated voiding of urine into bed or clothing, not due to any general medical condition

fetal alcohol syndrome A *congenital* disorder resulting from alcohol teratogenicity (i.e., the production, actual or potential, of pathological changes in the fetus, most frequently in the form of normal development of one or more organ systems; commonly referred to as birth defects), with the following possible dysmorphic categories: *central nervous system* dysfunction, birth deficiencies (such as low birth weight), facial abnormalities, and variable major and minor malformations. A safe level of alcohol use during pregnancy has not been established, and it is generally advisable for women to refrain from alcohol use during pregnancy

fetishism One of the *paraphilias*, characterized by marked distress over, or acting on, sexual urges involving the use of nonliving objects (fetishes), such as underclothing, stockings, or boots

flashback Hallucinogen persisting perception disorder or posthallucinogen perception disorder: reexperiencing, after ceasing the use of a hallucinogen, one or more of the perceptual symptoms that had been part of the hallucinatory experience while using the drug

flight of ideas An early continuous flow of accelerated speech with abrupt changes from one topic to another, usually based on understandable associations, distracting stimuli, or playing on words. When severe, however, this may lead to disorganized and incoherent speech. Flight of ideas is characteristic of *manic episodes*, but it may occur also in *organic mental disorders, schizophrenia, other psychoses*, and, rarely, acute reactions to stress

flooding(implosion) A behavior therapy procedure for phobias and other problems involving maladaptive anxiety, in which anxiety producers are presented in intense forms, either in imagination or in real life. The presentations, which act as desensitizers, are continued until the stimuli no longer produce disabling anxiety.

gender identity disorder One of the major groups of sexual and gender identity disorders, characterized by a strong and persistent identification with the opposite sex (cross-gender identification) and discomfort with one's assigned sex or a sense of inappropriateness in that gender role. Although onset is usually in childhood or adolescence, the disorder may not be presented clinically until adulthood. Manifestations include a repeated desire to be of the opposite sex, insistence that one has the typical feelings and reactions of the opposite sex, a belief that one was born the wrong sex, and transsexualism or preoccupation with one's primary and secondary sex characteristics in order to simulate the opposite sex.

hallucination A sensory perception in the absence of an actual external stimulus; to be distinguished from an *illusion*, which is a misperception or misinterpretation of an external stimulus. Hallucinations may involve any of the senses.

hyperactivity Excessive motor activity that may be purposeful or aimless; movements and utterances are usually more rapid than normal. Hyperactivity is a prominent feature of attention-deficit disorder, so much so that in DSM-IV the latter is called *attention-deficit hyperactivity disorder (ADHD)*.

hypomania A psychopathological state and abnormality of *mood* falling somewhere between normal *euphoria* and *mania*. It is characterized by unrealistic optimism, pressure of speech and activity, and a decreased need for *sleep*. Some people show increased creativity during hypomanic states, whereas others show poor judgment, irritability and irascibility.

identity crisis A loss of the sense of the sameness and historical continuity of one's self and an inability to accept or adopt the role one perceives as being expected by society. This is often expressed by isolation, withdrawal, extremism, rebelliousness, and negativity, and is typically triggered by a sudden increase in the strength of instructional *drives* in a milieu of rapid social evolution and technological change.

impulse control disorders Failing to resist an *impulse*, drive, or temptation to perform some act that is harmful to oneself or to others. The impulse may be resisted consciously, but it is consonant with the person', immediate, *conscious* wish. The act may be premeditated or unplanned. The person may display regret or guilt for the action or its consequences. In DSM-IV, this category includes *pathological gambling*, *kleptomania*, *pyromania*, intermittent explosive disorder, and *trichotillomania*.

labile Rapidly shifting (as applied to *emotions*), unstable

mania *Bipolar disorder;* a mood disorder characterized by excessive elation, inflated self-esteem and *grandiosity*, hyperactivity, agitation, and accelerated thinking and speaking. *Flight of ideas* may be present. A manic syndrome may also occur in *organic mental disorder*,.

-mania Formerly used as a nonspecific term for any type of "madness." Currently used as a suffix to indicate a morbid preoccupation with some kind of idea or activity, and/or a *compulsive* need to behave in some deviant way. Some examples are as follows:

egomania Pathological preoccupation with self.

kleptomania Compulsion to steal.

nymphomania Abnormal and excessive need or desire in the woman for sexual intercourse, see *satyriasis*.

pyromania Compulsion to set fires, an *impulse control disorder*.

trichotillomania Compulsion to pull one's own hair out, an *impulse disorder*.

manic episode A distinct period of time (usually lasting at least 1 week) of abnormally and persistently elevated, expansive, or irritable mood accompanied by such *symptoms* as inflated self-esteem or *grandiosity*, decreased need for sleep, overtalkativeness or *pressured speech*, *flight of ideas* or feeling that thoughts are racing, inattentiveness and distractibility, increased goal-directed activity (e.g., at work or school, socially or sexually), and involvement in pleasurable activities with high potential for painful consequences (e.g., buying sprees, sexual indiscretions, foolish business ventures). See *bipolar disorders*.

manic-depressive illness A term often used synonymously with *bipolar disorder*, as defined in DSM-IV.

mental health A state of being that is relative rather than absolute. The best indices of mental health are simultaneous success at working, loving, and creating, with the capacity for mature and flexible resolution of conflicts between *instincts*, *conscience*, important other people, and reality.

mental status examination The process of estimating psychological and behavioral function by observing the patient, eliciting his or her self-description, and using formal questioning. Included in the examination are 1) evaluation and assessment of any psychiatric condition present, including provisional *diagnosis and prognosis*, determination of degree of impairment, suitability for treatment, and indications for particular types of therapeutic intervention; 2) formulation of the personality structure of the subject, which may suggest the historical and developmental antecedents of whatever psychiatric condition exists; and 3) estimation of the subject's ability and willingness to participate appropriately in treatment. The mental status is reported in a series of narrative statements describing such things as *affect*, speech, thought content, perception, and *cognitive* functions. This examination is part of the general examination of all patients, although it may be markedly abbreviated in the absence of *psychopathology*.

mood disorders In DSM-IV, this category includes *depressive disorders*, *bipolar disorders*, *mood disorder due to a general medical condition*, and substance-induced (intoxication/ withdrawal) mood disorder

mood swing Fluctuation of a person's emotional tone between periods of elation and periods of depression

mutism, selective Elective mutism, a disorder of infancy, childhood, or adolescence characterized by persistent failure to speak in specific social situations by a child with demonstrated ability to speak. The mutism is not due to lack of fluency in the language being spoken or embarrassment about a speech problem

negativistic personality disorder A type of *passive-aggressive personality disorder* characterized by passive resistance to demands for adequate social and occupational performance and a negative attitude. Typical manifestations include inefficiency, procrastination, complaints of being victimized and unappreciated, irritability, criticism of and scorn for authority, and personal discontent. The person with this disorder alternates between hostile assertions of independence and contrite, dependent behavior

obsessive-compulsive disorder An *anxiety disorder* characterized by obsessions, compulsions, or both, that are time-consuming and interfere significantly with normal routine, occupational functioning, usual social activities, or relationships with others. See *compulsion; obsession*.

oppositional defiant order A patten of negativistic and hostile behavior in a child that lasts at least 6 months. *Symptoms* may include losing one's temper, arguing with adults or actively refusing their requests, deliberately annoying others, being easily annoyed, angry, and resentful, and being spiteful or vindictive

overanxious disorder An anxiety disorder of childhood and adolescence, sometimes considered equivalent to the adult diagnosis of *generalized anxiety disorder*. Symptoms include multiple, unrealistic anxieties concerning the quality of one's performance in school and in sports, hobbies, money matters, punctuality, health, or appearance. The patient is tense and unable to relax and has recurrent somatic complaints for which no physical cause can be found

panic attack A period of intense fear or discomfort, with the abrupt development of a variety of *symptoms* and fears of dying, going crazy, or losing control that reach a crescendo within 10 minutes. The symptoms may include shortness of breath or smothering sensations, dizziness, faintness, or feelings of unsteadiness, trembling or shaking, sweating, choking, nausea or abdominal distress, flushes or chills, and chest pain or discomfort.

Panic attacks occur in several *anxiety disorders*. In *panic disorder* they are typically unexpected and happen "out of the blue." In *social phobia* and *simple phobia* they are cued and occur when exposed to or in anticipation of a situational trigger. These attacks occur also in *posttraumatic stress disorder*.

phobia *Fear* cued by the presence or anticipation of a specific object or situation, exposure to which almost invariably provokes an immediate *anxiety* response or *panic attack* even though the subject recognizes that the fear is excessive or unreasonable. The phobic stimulus is avoided or endured with marked distress. In earlier psychoanalytic literature, phobia was called *anxiety hysteria*.

Two types of phobia have been differentiated: specific phobia (simple phobia) and social phobia. Specific phobia is subtyped on the basis of the object feared. The natural environment (animals, insects, storms, water, etc.), blood, injection, or injury; situations (cars, airplanes, heights, tunnels, etc.); and other situations that may lead to choking, vomiting, or contracting an illness are all specific phobias.

In social phobia (social anxiety disorder), the persistent fear is of social situations that might expose one to scrutiny by others and induce one to act in a way or show anxiety symptoms that will be humiliating or embarrassing. Avoidance may be limited to one or only a few situations, or it may occur in most social situations. Performing in front of others or social interactions may be the focus of concern. It is sometimes difficult to distinguish between social phobia and *agoraphobia* when social avoidance accompanies panic attacks. *Avoidant disorder* has been used to refer to social phobia occurring in childhood and adolescence.

Some of the common phobias are (add "abnormal fear of" to each entry):

achluophobia Darkness, **acrophobia** Heights, **agoraphobia** Open spaces or leaving the familiar setting of the home, **ailurophobia** Cats, **algophobia** Pain, **androphobia** Men, **autophobia** Being alone or solitude, **bathophobia** Depths, **claustrophobia** Closed spaces, **cynophobia** Dogs, **demophobia** Crowds, **erhthrophobia** Blushing; sometimes used to refer to the blushing itself, **gynophobia** Women, **hypnophobia** Sleep, **mysophobia** Dirt and germs, **panphobia** Everything, **pedophobia** Children, **xenophobia** Strangers

posttraumatic stress disorder (PTSD) An *anxiety disorder* in which exposure to an exceptional mental or physical stressor is followed, sometimes immediately and sometimes not until 3 months or more after the stress, by persistent reexperiencing of the event, avoidance of stimuli associated with the trauma or numbing of general responsiveness, and manifestations of increased arousal. The trauma typically includes experiencing, witnessing, or confronting an event that involves actual or threatened death or injury, or a threat to the physical integrity of oneself or others, with an immediate reaction of intense fear, helplessness, or horror.

Reexperiencing the trauma may take several forms: recurrent, intrusive, and distressing recollections (images, thoughts, or perceptions) of the event, recurrent distressing dreams of the event, sudden feeling as if the event were recurring or being relived (including dissociative flashback episodes), or intense psychological distress or physiological reactivity if exposed to internal or external cues that symbolize or resemble some part of the event.

The affected person tries to avoid thoughts or feelings associated with the event and anything that might arouse recollection of it. There may be *amnesia* for an important aspect of the trauma. The person may lose interest in significant activities, feel detached or estranged from others, or have a sense of a foreshortened future.

The person may have difficulty failing or staying asleep, be irritable or have angry outbursts, experience problems concentrating, and have an exaggerated startle response.

BEST COPY AVAILABLE

schizophrenia A group of idiopathic *psychotic disorders* characterized by both positive and negative *symptoms* associated with disturbance in one or more major areas of functioning such as work, academic development or achievement, interpersonal relations, and self-care. Positive symptoms include *delusions*, which may be bizarre in nature, hallucinations, especially auditory, disorganized speech, inappropriate *affect*, and disorganized behavior. Negative symptoms include flat affect, *avolition*, *alogia*, and *anbedonia*. Duration is variable. ICD-10 requires that continuous signs of the disturbance persist for at least 1 month; DSM-IV requires a minimum of 6 months.

separation anxiety disorder A disorder with onset before the age of 18 consisting of inappropriate *anxiety* concerning separation from home or from persons to whom the child is attached. Among the *symptoms* that may be seen are unrealistic concern about harm befalling or loss of major attachment figures; refusal to go to school (school phobia) in order to stay at home and maintain contact with this figure; refusal to go to *sleep* unless close to this person; clinging, nightmares about the theme of separation; and development of physical symptoms or mood changes (apathy, *depression*) when separation occurs or is anticipated.

sleep terror disorder One of the *parasomnias* characterized by *panic* and confusion when abruptly awakening from *sleep*. This usually begins with a scream and is accompanied by intense *anxiety*. The person is often confused and disoriented after awakening. No detailed dream is recalled, and there is *amnesia* for the episode. Sleep terrors typically occur during the first third of the major sleep episode. Contrast with *nightmare disorder*.

steroids, anabolic Synthetic derivatives of testosterone used medically to promote protein anabolism. They can be drugs of abuse used to aid in body building. They sometimes produce an initial sense of well-being replaced after repeated use by lack of energy, irritability, and unhappiness. Continued use may lead to such serious complications as severe *depres*sion, outbursts of violence, and liver disease.

systematic desensitization A *behavior therapy* procedure widely used to modify behaviors associated with *phobias*. The procedure involves the construction of a hierarchy of anxiety-producing stimuli by the subject, and gradual presentation of the stimuli until they no longer produce anxiety. Also called desensitization. See also *reciprocal inhibition*.

Tarasoff decision A California court decision that essentially imposes a duty on the therapist to warn the appropriate person or persons when the therapist becomes aware that the patient may present a risk of harm to a specific person or persons.

thought disorder A disturbance of speech, communication, or content of thought, such as *delusions*, *ideas of reference*, poverty of thought, *flight of ideas*, *preservation*, *loosening of associations*, and so forth. A thought disorder can be caused by a functional emotional disorder or an organic condition. A formal thought disorder is a disturbance in the form of thought rather than in the content of thought (e.g., loosening of associations).

tic An involuntary, sudden, rapid, recurrent, nonrhythmic stereotyped motor movement or vocalization. A tic may be an expression of an emotional conflict, the result of neurologic disease, or an effect of a drug (especially a stimulant or other *dopamine agonist*).

tic disorders In DSM-IV, this category includes *Tourette's disorder*, chronic motor or vocal tic disorder, transient tic disorder, and tic disorder not otherwise specified, all beginning before the age of 18 years. Chronic tics may occur many times a day, nearly every day, or intermittently over a period of more than a year. Transient tics do not persist for longer than 12 consecutive months.

Tourette's disorder A *tic disorder* consisting of multiple motor and vocal tics that occur in bouts, either concurrently or separately, almost every day or intermittently over a period of more than 12 months.

trichotillomania Pathological hair pulling that results in noticeable hair loss. As in other *impulse control disorders*, an increasing sense of tension or affective arousal immediately precedes an episode of hair pulling, which is then followed by a sense of pleasure, gratification, or relief.

Glossary of Acronyms and Laws For Special Educators Of Students with Emotional/Behavioral Disorders*

A

AABT	ASSOCIATION FOR THE ADVANCEMENT OF BEHAVIOR THERAPY
AACAP	AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY
AADA	ALCOHOL AND DRUG ABUSE
AASA	AMERICAN ASSOCIATION OF SCHOOL ADMINISTRATORS
ABA	AMERICAN BAR ASSOCIATION
	APPLIED BEHAVIOR ANALYSIS
	ASSOCIATION FOR BEHAVIOR ANALYSIS
A-B-C	ANTECEDENT-BEHAVIOR-CONSEQUENCE
ACA	AMERICAN COUNSELING ASSOCIATION
ACCH	ASSOCIATION FOR THE CARE OF CHILDREN'S HEALTH
ACLD	ASSOCIATION FOR CHILDREN WITH LEARNING DISABILITIES
ADA	AMERICANS WITH DISABILITIES ACT (P.L. 101-336,1990)
ADAA	ANTI-DRUG ABUSE ACT (P.L. 100-790,1988)
ADD	ATTENTION DEFICIT DISORDER
ADHD	ATTENTION DEFICIT/HYPERACTIVITY DISORDER
AFDC	AID TO FAMILIES WITH DEPENDENT CHILDREN
AMI-CAN	ALLIANCE FOR THE MENTALLY ILL-CHILD AND ADOLESCENT NETWORK
AOA	AMERICAN ORTHOPSYCHIATRIC ASSOCIATION
APA	AMERICAN PSYCHIATRIC ASSOCIATION
	AMERICAN PSYCHOLOGICAL ASSOCIATION
APE	ADAPTIVE PHYSICAL EDUCATION
ARC	ASSOCIATION FOR RETARDED CITIZENS
ASA	AUTISM SOCIETY OF AMERICA

B

BD	BEHAVIOR/BEHAVIORAL DISORDER/DISORDERED
BIP	BEHAVIOR INTERVENTION PLAN
BMOD	BEHAVIOR MODIFICATION
BP	BEHAVIOR PROBLEM(S)

C

CAP	CLIENT ASSISTANCE PROGRAM
	COMMUNITY ACTION PROGRAM
CAPP	COLLABORATION AMONG PARENTS & HEALTH PROFESSIONALS
CASE	COUNCIL FOR ADMINISTRATORS OF SPECIAL EDUCATION (CEC)
CASSP	CHILD & ADOLESCENT SERVICE SYSTEM PROGRAM
CAT	CALIFORNIA ACHIEVEMENT TEST
	CHILDRENS APPERCEPTION TEST
	COGNITIVE ABILITIES TEST
	CONSULTATION ASSISTANCE TEAM
CBA	CURRICULUM-BASED ASSESSMENT
CBCL	CHILD BEHAVIOR CHECKLIST (ACHENBACH)
CBE	CURRICULUM-BASED EVALUATION
CBM	CURRICULUM-BASED MEASUREMENT
CCBD	COUNCIL FOR CHILDREN WITH BEHAVIORAL DISORDERS (CEC)
CD	CHEMICALLY DEPENDENT
	CONDUCT DISORDER
CDC	CENTER FOR DISEASE CONTROL
CDF	CHILDREN'S DEFENSE FUND
CE	CAREER EDUCATION
CEC	COUNCIL FOR EXCEPTIONAL CHILDREN
CER	CONDITIONED EMOTIONAL RESPONSE
CFS	CHILDREN AND FAMILY SERVICES
CHADD	CHILDREN WITH ATTENTION DEFICIT DISORDER
CHEN	COMMUNITY HEALTH EDUCATION NETWORK
CHINS	CHILDREN IN NEED OF SERVICES
CHIPS	CHIDREN IN NEED OF PROTECTIVE SERVICES
CMHC	COMMUNITY MENTAL HEALTH CENTER
CMHSP	CHILDREN'S MENTAL HEALTH SERVICES PROGRAM (P.L. 102-321)
CLD	CULTURALLY AND LINGUISTICALLY DIVERSE
CLDES	CULTURALLY AND LINGUISTICALLY DIVERSE EXCEPTIONAL STUDENTS
COH	COMMITTEES OF THE HANDICAPPED
CPS	CHILD PROTECTIVE SERVICES
CRF	CONTINUOUS REINFORCEMENT SCHEDULE
CRS	CONNERS'RATING SCALES

CSE	COMMITTEE ON SPECIAL EDUCATOIN
CSP	COMMUNITY SUPPORT PROGRAM
CSSP	COMMUNITY SOCIAL SERVICES PROGRAM
CST	CHILD STUDY TEAM
CTIC	COMMUNITY TRANSITION INTERAGENCE COMMITTEE
CWLA	CHILD WELFARE LEAGUE OF AMERICA

D

DCCD	DIVISION FOR CHILDREN WITH COMMUNICATION DISORDERS (CEC)
DD	DEVELOPMENTAL DISABILITIES
	DUALLY DIAGNOSED (e.g. EBD & CHEMICAL ABUSE)
DDEL	DIVISION FOR CULTURALLY AND LINGUISTICALLY DIVERSE EXCEPTIONAL LEARNERS(CEC)
DEC	DIVISION OF EARLY CHILDHOOD (CEC)
DHS	DEPARTMENT OF HUMAN SERVICES
DISES	DIVISION OF INTERNATIONAL SPECIAL EDUCATION SERVICES (CEC)
DLD	DIVISION FOR LEARNING DISABILITIES (CEC)
DOE	DEPARTMENT OF EDUCATION
DR(O.A.H.I)	DIFFERENTIAL REINFORCEMENT PROCEDURES (OTHER. ALTERNATE. HIGH RATES. INCOMPATIBLE --BEHAVIORS)
DREDF	DISABILITY RIGHTS EDUCATION AND DEFENSE FUND
DRS	DEPARTMENT OF REHABILITATION SERVICES
DSM	DIAGNOSTIC AND STATISTICAL MANUAL (1994 DSM-IV)
DTP	DAY TREATMENT PROGRAMS
DVH	DIVISION ON VISUAL HANDICAPS (CEC)
DVR	DIVISION OF VOCATIONAL REHABILITATION (DEPT OF JOBS & TRAINING)

E

EAHC	EDUCATION FOR ALL HANDICAPPED CHILDREN ACT (P.L. 94-142,1975) AMENDED (P.L. 99-457,1986-INFANTS/TODDLER PROGRAMS)
EBD	EMOTIONAL BEHAVIORAL DISORDERS
ECFE	EARLY CHILDHOOD FAMILY EDUCATION
ECSE	EARLY CHILDHOOD SPECIAL EDUCATION
EDGAR	EDUCATION GENERAL ADMINISTRATIVE REGULATIONS
EEOC	EQUAL EMPLOYMENT OPPORTUNITY COMMISSION (U.S.)
EH	EMOTIONALLY HANDICAPPED

EHA	EDUCATION OF THE HANDICAPPED ACT (PART B, PL 94-142)
EI	EMOTIONALLY IMPAIRED
EMH	EDUCABLE MENTALLY HANDICAPPED
EMR	EDUCABLE MENTALLY RETARDED
EPSDT	EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT
ERIC	EDUCATIONAL RESEARCH AND IMPROVEMENT CENTER EDUCATIONAL RESOURCE INFORMATION CENTER
ERT	EDUCATIONAL RESOURCE TEACHER
ESEA	ELEMENTARY AND SECONDARY EDUCATION ACT (1965)
ESL	ENGLISH AS A SECOND LANGUAGE
ETS	EDUCATIONAL TESTING SERVICE

F

FA	FAMILIES ANONYMOUS
FAPE	FREE APPROPRIATE PUBLIC EDUCATION
FAS	FETAL ALCOHOL SYNDROME
FCSS	FAMILY COMMUNITY SUPPORT SERVICES
FERPA	FAMILY EDUCATIONAL RIGHTS and PRIVACY ACT
FFCM	FEDERATION OF FAMILIES FOR CHILDREN'S MENTAL HEALTH
FFTA	FOSTER FAMILY-BASED TREATMENT ASSOCIATION
FICC	FEDERAL INTERAGENCY COORDINATING COUNCIL
FSA	FAMILY SERVICES OF AMERICA
FYSB	FAMILY & YOUTH SERVICE BUREAU (U.S. DEPT. OF HEALTH & HUMAN SERVICES)

G

GA/EA	GENERAL ASSISTANCE/EMERGENCY ASSISTANCE
GATE	GIFTED AND TALENTED EDUCATION
GE	GRADE EQUIVALENT
GED	GENERAL EDUCATION DIPLOMA

H

HCPA	HANDICAPPED CHILDRENS PROTECTION ACT (P.L. 99-372, 1986, AMENDMENT TO P.L. 94-142)
HEATH	HIGHER EDUCATION AND THE HANDICAPPED
HECB	HIGHER EDUCATION COORDINATING BOARD
HEW	HEALTH EDUCATION AND WELFARE

HHS	HEALTH AND HUMAN SERVICES
HI	HEARING IMPAIRED
HIO	HEALTH INSURANCE ORGANIZATION
HMO	HEALTH MAINTENANCE ORGANIZATION

I

IASA	IMPROVING AMERICA'S SCHOOLS ACT
IARET	INTERNATIONAL ASSOCIATION FOR THE RIGHT TO EFFECTIVE TREATMENT
ICC	INTERAGENCY COORDINATING COUNCIL
ICD	INTERNATIONAL CLASSIFICATION SYSTEM
ICF	INTERMEDIATE CARE FACILITY
ICP	INDIVIDUAL CAREER PLAN
IDEA	INDIVIDUALS WITH DISABILITIES EDUCATION ACT (P.L.101-457.1990. AMENDMENTS TO P.L. 94-142)
IDT	INTER-DISCIPLINARY TEAM
IEE	INDEPENDENT EDUCATIONAL EVALUATION
IEIC	INTERAGENCY EARLY INTERVENTION COMMITTEE
IEP	INDIVIDUALIZED EDUCATION PLAN/PROGRAM
IEU	INTERMEDIATE EDUCATIONAL UNIT
IFCSP	INDIVIDUAL FAMILY COMMUNITY SUPPORT PLAN
IFSP	INDIVIDUALIZED FAMILY SERVICES PLAN
IHE	INSTITUTION OF HIGHER EDUCATION
IHP	INDIVIDUAL HABILITATION PLAN
IIP	INDIVIDUALIZED INSTRUCTIONAL PLAN
ILP	INDIVIDUAL LEARNING PLAN
IMS	INFORMATIONAL MANAGEMENT SYSTEM INSTRUCTIONAL MANAGEMENT SYSTEM
IPP	INDIVIDUALIZED PROGRAM PLAN
IQ	INTELLIGENCE QUOTIENT
I&R	INFORMATION AND REFERRAL
ISD	INDEPENDENT SCHOOL DISTRICT
ISP	INDIVIDUALIZED SERVICES PLAN
ITP	INDIVIDUALIZED TRANSITION PLAN INDIVIDUALIZED TREATMENT PLAN

J

JD	JUVENILE DELINQUENT
JJ	JUVENILE JUSTICE
JJDPA	JUVENILE JUSTICE AND DELINQUENCY PREVENTION ACT (P.L. 93-415.1974)
JOBS	JOB OPPORTUNITIES AND BASIC SKILLS
JTPA	JOB TRAINING PARTNERSHIP ACT (P.L. 97-300.1983)
JWB	JUVEINLE WELFARE BOARD

K

KTEA	KAUFMAN TEST OF EDUCATIONAL ACHIEVEMENT

L

LAC	LOCAL ADVISORY COUNCIL (MENTAL HEALTH)
LCC	LOCAL COORDINATING COUNCIL (MENTAL HEALTH)
LCP	LICENSED CONSULTING PSYCHOLOGIST
LD	LEARNING DISABLED
LEA	LOCAL EDUCATION AGENCY
LEP	LIMITED ENGLISH PROFICIENCY
LI	LOW INCIDENCE HANDICAPPING CONDITION
LIA	LOCAL INTERAGENCY AGREEMENT
LRA	LEAST RESTRICTIVE ALTERNATIVE
LRE	LAW RELATED EDUCATION
	LEAST RESTRICTIVE ENVIRONMENT
LST	LEARNER SUPPORT TEAM
LSW	LICENSED SOCIAL WORKER
LTM	LONG TERM MEMORY

M

MA	MEDICAL ASSISTANCE
	MENTAL AGE
MCH	MATERNAL AND CHILD HEALTH
MDC	MULTI-DISCIPLINARY COMMITTEE
MDT	MULTI-DISCIPLINARY TEAM
MH	MENTAL HANDICAP
MI	MENTAL ILLNESS/MENTALLY ILL
	MENTALLY IMPAIRED

MMPI	MINNESOTA MULTIPHASIC PERSONALITY INVENTORY
MR	MENTALLY RETARDED
N	
NACA	NATIONAL ASSOCIATION OF CHILD ADVOCATES
NACHC	NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS
NADAP	NATIONAL ASSOCIATION ON DRUG ABUSE PROBLEMS. INC
NAESP	NATIONAL ASSOCIATION OF ELEMENTARY SCHOOL PRINCIPALS
NAHC	NATIONAL ASSOCIATION OF HOMES FOR CHILBREN
NAMI	NATIONAL ALLIANCE FOR THE MENTALLY ILL
NAPAS	NATIONAL ASSOCIATION OF PROTECTION AND ADVOCACY SYSTEMS
NAPPH	NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS
NAPSEC	NATIONAL ASSOCIATION OF PRIVATE SCHOOLS FOR EXCEPTIONAL CHILDREN
NAPTCC	NATIONAL ASSOCIATION OF PSYCHIATRIC TREATMENT CENTERS FOR CHILDREN
NARF	NATIONAL ASSOCIATION OF REHABILITATION FACILITIES
NASADAD	NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS
NASB	NATIONAL ASSOCIATION OF SCHOOL BOARDS
NASBE	NATIONAL ASSOCIATION OF STATE BOARDS OF EDUCATION
NASMHPD	NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS
NASDSE	NATIONAL ASSOCIATION OF STATE DIRECTORS OF SPECIAL EDUCATION
NASNSA	NATIONAL ASSOCIATION OF SPECIAL NEEDS STATE ADMINISTRATORS
NASP	NATIONAL ASSOCIATION OF SCHOOL PSYCHOLOGISTS
NASDE	NATIONAL ASSOCIATION OF STATE DIRECTORS OF SPECIAL EDUCATION
NASSP	NATIONAL ASSOCIATION OF SECONDARY SCHOOL PRINCIPALS
NASW	NATIONAL ASSOCIATION OF SOCIAL WORKERS
NAVESNP	NATIONAL ASSOCIATION OF VOCATIONAL EDUCATION SPECIAL NEEDS PERSONNEL
NCAS	NATIONAL COALITION OF ADVOCATES FOR STUDENTS
NCBE	NATIONAL CLEARINGHOUSE FOR BILINGUAL EDUCATION
NCCAFV	NATIONAL COUNCIL ON CHILD ABUSE AND FAMILY VIOLENCE
NCLH	NATIONAL CENTER FOR LAW AND THE HANDICAPPED
NDPC	NATIONAL DROPOUT PREVENTION CENTER
NEA	NATIONAL EDUCATION ASSOCIATION
NFB	NATIONAL FEDERATION OF THE BLIND
NFP	NOT-FOR-PROFIT

NICHCY	NATIONAL INFORMATION CENTER FOR HANDICAPPED CHILDREN AND YOUTH
NIDA	NATIONAL INSTITUTE ON DRUG ABUSE
NIDDR	NATIONAL INSTITUTE ON DISABILITY REHABILITATION RESEARCH
NIH	NATIONAL INSTITUTE OF HEALTH
NIMH	NATIONAL INSTITUTE OF MENTAL HEALTH
NMHA	NATIONAL MENTAL HEALTH ASSOCIATION
NMHCA	NATIONAL MENTAL HEALTH CONSUMERS ASSOCIATION
NMSA	NATIONAL MIDDLE SCHOOL ASSOCIATION
NNPC	NATIONAL NETWORK OF PARENT CENTERS
NNRYS	NATIONAL NETWORK OF RUNAWAY AND YOUTH SERVICES
NOCCWA	NATIONAL ORGANIZATION OF CHILD CARE WORKERS ASSOCIATION
NRCCAN	NATIONAL RESOURCE CENTER FOR CHILD ABUSE AND NEGLECT
NSAC	NATIONAL SOCIETY FOR CHILDREN & ADULTS WITH AUTISM

O

OBE	OUTCOME-BASED EDUCATION
OCD	OBSESSIVE COMPULSIVE DISORDER
OCR	OFFICE OF CIVIL RIGHTS
ODD	OPPOSITIONAL DEFIANT DISORDER
OERI	OFFICE OF EDUCATIONAL RESEARCH AND IMPROVEMENT
OH	ORTHOPEDICALLY HANDICAPPED
OHI	OTHER HEALTH IMPAIRMENTS
OJJDP	OFFICE OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION
OJT	ON-THE-JOB TRAINING
OMB	OFFICE OF MANAGEMENT AND BUDGET
OSEP	OFFICE OF SPECIAL EDUCATION PROGRAMS (FEDERAL)
OSERS	OFFICE OF SPECIAL EDUCATION & REHABILITATIVE SERVICES
OT	OCCUPATIONAL THERAPIST/THERAPY

P

PA	PARENTS ANONYMOUS
P&A	PROTECTION AND ADVOCACY (SYSTEM)
PDD	PERVASIVE DEPRRIVATION DISORDER PERVASIVE DEVELOPMENTAL DISORDER
PDR	PHYSICIANS DESK REFERENCE
PE	PHYSICAL EDUCATION

PH	PHYSICALLY HANDICAPPED
PKU	PHENYLKETONURIA
P.L.	PUBLIC LAW
PMC	PARENT OF A MINOR CARETAKER (FOR AFCD)
POHI	PHYSICAL AND OTHER HEALTH IMPAIRED
PPT	PUPIL PERSONNEL TEAM
PSEN	PUPILS WITH SPECIAL EDUCATION NEEDS
PSS	PRESCHOOL SCREENING PROGRAM
PT	PHYSICAL THERAPIST.
PTA	PARENT TEACHER ASSOCIATION
PTIC	PARENT TRAINING AND INFORMATION CENTER
PTO	PARENT TEACHER ORGANIZATION
PTSA	PARENT TEACHER STUDENT ASSOCIATION
PTSD	POST TRAUMATIC STRESS DISORDER

Q

R

RCF	RESIDENTIAL CARE FACILITY
R&D	RESEARCH AND DEVELOPMENT
RE-ED	RE-EDUCATION
RET	RATIONAL EMOTIVE THERAPY
RHVA	RUNAWAY AND HOMELESS YOUTH ACT (P.L. 96-509.1980)
RISC	REGIONAL INTERAGENCY SYSTEMS CHANGE PROJECTS
RSA	REHABILITATION SERVICES ADMINISTRATION
RT	RECREATION THERAPY
RTC	RESIDENTIAL TREATMENT CENTER
SAMHSA	SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
SBST	SCHOOL-BASED SUPPORT TEAM
SAT	SCHOLASTIC APTITUDE TEST
SCH	SERVICES TO CHILDREN WITH HANDICAPS
	STATE COUNCIL FOR THE HANDICAPPED
SDE	STATE DEPARTMENT OF EDUCATION
SE	SPECIAL EDUCATION
	SUPPORTED EMPLOYMENT
SEA	STATE EDUCATION AGENCY

SEAC	SPECIAL EDUCATION ADVISORY COMMITTEES
SED	SERIOUS EMOTIONAL DISTURBANCE SERIOUSLY EMOTIONALLY DISTURBED
SEDNET	SERIOUS EMOTIONAL DISTURBANCE NETWORK SPECIAL EDUCATION NETWORK TEAM
SEEC	SPECIAL EDUCATION EARLY CHILDHOOD
SEP	SPECIAL EDUCATION PROGRAMS (OFFICE OF)
SERT	SPECIAL EDUCATION RESOURCE TEACHER
SH	SEVERELY HANDICAPPED
SIB	SELF-INJURIOUS BEHAVIOR
SIDS	SUDDEN INFANT-DEATH SYNDROME
SLA	SUPPORTED LIVING ARRANGEMENT
SLBP	SPECIAL LEARNING AND BEHAVIOR PROBLEMS
SLD	SPECIFIC LEARNING DISABILITY
SM	SOCIALLY MALADJUSTED
SMHRCY	STATE MENTAL HEALTH REPRESENTATIVE FOR CHILDREN AND YOUTH
SOP	STATE OPERATED PROGRAMS
SPED	SPECIAL EDUCATION
SR, S-R	STIMULUS-RESPONSE
SSA	SOCIAL SECURITY ADMINISTRATION
SSI	SUPPLEMENTAL SECURITY INCOME
SST	STUDENT SUPPORT TEAM
ST	SPEECH THERAPIST
STAR	SYSTEM OF TECHNOLOGY TO ACHIEVE RESULTS
STIC	STATE TRANSITION INTERAGENCY COMMITTEE
STM	SHORT TERM MEMORY
SW	SHELTERED WORKSHOP SOCIAL WORKER

T

TA	TECHNICAL ASSISTANCE
TAG	THE ASSOCIATION FOR THE GIFTED (CEC)
TAM	TECHNOLOGY AND MEDIA DIVISION (CEC)
TAPP	TECHNICAL ASSISTANCE TO PARENT PROGRAMS
TASH	THE ASSOCIATION FOR PERSONS WITH SEVERE HANDICAPS
TAT	TEACHER ASSISTANCE TEAM

TBI	TRAMATIC BRAIN INJURY
TDD	TELECOMMUNICATION DEVICE FOR THE DEAF
TED	TEACHER EDUCATION DIVISION (CEC)
TMH	TRAINABLE MENTALLY HANDICAPPED
TMR	TRAINABLE MENTALLY RETARDED
TSES	TOTAL SPECIAL EDUCATION SYSTEM
TT	TECHNICAL TUTOR
TTY	TELETYPEWRITER
U	
UAP	UNIVERSITY AFFILIATED PROGRAM
UPC	UNITED CEREBAL PALSY
USOE	UNITED STATES OFFICE OF EDUCATION
V	
VAC	VOCATIONAL ADJUSTMENT COUNSELOR
VE	VOCATIONAL EDUCATION
VH	VISUALLY HANDICAPPED
VI	VISUAL IMPAIRMENT
WIC	WOMEN INFANTS AND CHILDREN (NUTRITION PROGRAM)
WIS	WELFARE INFORMATION SYSTEM I
WS	WAIVERED SERVICES
Z	
Z	STANDARD TEST SCORE

Federal Laws

P L 89-313	EDUCATION TO IMPROVE OPPORTUNITIES FOR LOW-INCOME UNDERACHIEVERS (CHAPTER 1. TITLE 1)
P L 91-230	THE EDUCATION OF THE HANDICAPPED ACT. 1970
P L 90-247	PRIVACY RIGHTS OF PARENTS AND STUDENTS IN STATE ADMINISTERED PROGRAMS
P L 93-112	SECTION 503-AFFIRMATIVE ACTION FOR EMPOLYMENT. AND 504-PROHIBITS DISCRIMINATION BASED ON HANDICAP. OF REHABILITATION ACT 1973
P L 93-415	JUVENILE JUSTICE AND DELINQUENCY PREVENTION ACT. 1974
P L 94-142	EDUCATION FOR ALL HANDICAPPED CHILDRENS' ACT. 1975
P L 94-482	VOCATIONAL EDUCATION AMENDMENTS. 1976
P L 97-35	CHAPTER 1 CONSOLIDATION AND IMPROVEMENT ACT. 1982
P L 97-248	TAX EQUITY AND FISCAL RESPONSIBILITY ACT. 1982
P L 97-300	JOB TRAINING PARTNERSHIP ACT. 1983
P L 98-524	CARL PERKINS ACT. 1984
P L 99-372	HANDICAPPED CHILDREN'S PROTECTION ACT. 1986
P L 99-457	EHA AMENDMENTS FOR INFANTS AND TODDLERS. 1986
P L 100-790	ANTI-DRUG ABUSE ACT. 1988
P L 101-336	AMERICANS WITH DISABILITIES ACT. 1990
P L 101-476	INDIVIDUALS WITH DISABILITIES ACT. 1990
P L 102-321	CHILDREN'S MENTAL HEALTH SERVICES PROGRAM

CHILD'S MENTAL HEALTH

ommunities together

GLOSSARY

Children's and Adolescents' Mental Health: A Glossary of Terms

This glossary contains terms used frequently when dealing with the mental health needs of children. The list is alphabetical. Words highlighted by *italics* have their own separate definitions. The term *service* or *services* is used frequently in this glossary. The reader may wish to look up *service* before reading the other definitions.

The terms in this glossary describe ideal services. This help may not be available in all communities. The Comprehensive Community Mental Health Services for Children Program, administered by the Center for Mental Health Services (CMHS), has 22 grantees in 18 States that are demonstrating these services. For more information about children's mental health issues or services, call the CMHS National Mental Health Services Knowledge Exchange Network (KEN): 1.800.789.2647.

Accessible Services — Services that are affordable, located nearby, and are open during evenings and weekends. Staff is sensitive to and incorporates individual and cultural values. Staff is also sensitive to barriers that may keep a person from getting help. For example, an adolescent may be more willing to attend a support group meeting in a church or club near home, rather than travel to a mental health center. An accessible service can handle consumer demand without placing people on a long waiting list.

Appropriate Services — Designed to meet the specific needs of each individual child and family. For example, one family may need *day treatment* services while another family may need *home-based services*. Appropriate services for one child or family may not be appropriate for another family. Usually the most appropriate services are in the child's community.

Assessment — A professional review of a child's and family's needs that is done when they first seek services from a *caregiver*. The assessment of the child includes a review of physical and mental health, intelligence, school performance, family situation, and behavior in the community. The assessment identifies the strengths of the child and family. Together, the *caregiver* and family decide what kind of treatment and supports, if any, are needed.

Caregiver — A person who has special training to help people with mental health problems. Examples of people with this special training are social workers, teachers, psychologists, psychiatrists, and mentors.

Case Manager — An individual who organizes and coordinates services and supports for children with mental health problems and their families. (Alternate terms: service coordinator, advocate, and facilitator.)

Case Management — A service that helps people arrange *appropriate and available services* and supports. As needed, a *case manager* coordinates mental health, social work, education, health, vocational, transportation, advocacy, *respite*, and recreational services. The *case manager* makes sure that the child's and family's changing needs are met. (This definition does not apply to *managed care*.)

BEST COPY AVAILABLE

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration • Center for Mental Health Services
5600 Fishers Lane Room 13-103 • Rockville Maryland 20857 • Telephone 301 443 2792

CARING FOR EVERY CHILD'S MENTAL HEALTH: Communities Together Campaign

For information about childrens mental health contact the CMHS Knowledge Exchange Network
P.O. Box 42490 • Washington DC 20015 • Toll-free 1800 789 2647 • ~~FAX [illegible]~~
FAX 301 984 8796 • TTY 301 443 9006 • CMHS Electronic Bulletin Board 1 800 790 2647

494

SAMHSA

Child Protective Services — Designed to safeguard the child when there is suspicion of abuse, neglect, or abandonment, or where there is no family to take care of the child. Examples of help delivered in the home include financial assistance, vocational training, homemaker services, and day care. If in-home supports are insufficient, the child may be removed from the home on a temporary or permanent basis. The goal is to keep the child with his or her family whenever possible.

Children and Adolescents at Risk for Mental Health Problems — Children at higher risk for developing mental health problems when certain factors occur in their lives or environment. Some of these factors are physical abuse, emotional abuse or neglect, harmful stress, discrimination, poverty, loss of loved one, frequent moving, alcohol and other drug use, trauma, and exposure to violence.

Continuum of Care — A term that implies a progression of services that a child would move through, probably one at a time. The more up-to-date idea is one of comprehensive services. See *systems of care* and *wraparound services*.

Coordinated Services — Child-serving organizations, along with the family, talk with each other and agree upon a *plan of care* that meets the child's needs. These organizations can include mental health, education, juvenile justice, and child welfare. *Case management* is necessary to coordinate services. (Also see *family-centered services* and *wraparound services*.)

Crisis Residential Treatment Services — Short-term, round-the-clock help provided in a non-hospital setting during a crisis. For example, when a child becomes aggressive and uncontrollable despite in-home supports, the parent can have the child temporarily placed in a *crisis residential treatment service*. The purpose of this care is to avoid *inpatient hospitalization*, to help stabilize the child, and to determine the next appropriate step.

Cultural Competence — Help that is sensitive and responsive to cultural differences. *Caregivers* are aware of the impact of their own culture and possess skills that help them provide services that are culturally appropriate in responding to people's unique cultural differences, such as race and ethnicity, national origin, religion, age, gender, sexual orientation, or physical disability. They adapt their skills to fit a family's values and customs.

Day Treatment — Day treatment includes special education, counseling, parent training, vocational training, skill building, crisis intervention, and recreational therapy. It lasts at least 4 hours a day. Day treatment programs work with mental health, recreation, and education organizations and may be provided by them.

DSM-IV (*Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition) — An official manual of mental health problems developed by the American Psychiatric Association. This reference book is used by psychiatrists, psychologists, social workers, and other health and mental health care providers to understand and diagnose a mental health problem. Insurance companies and health care providers also use the terms and explanations in this book when they discuss mental health problems.

Early Intervention — A process for recognizing warning signs that individuals are at risk for mental health problems and taking early action against factors that put them at risk. Early intervention can help children get better more quickly and prevent problems from becoming worse.

Emergency and Crisis Services — A group of services that are available 24 hours a day, 7 days a week, to help during a mental health emergency. When a child is thinking about suicide, these services could save his or her life. Examples: telephone crisis hotlines, crisis counseling, *crisis residential treatment services*, crisis outreach teams, and crisis respite care.

Family-Centered Services — Help designed for the specific needs of each individual child and his or her family. Children and families should not be expected to fit into services that don't meet their needs. See *appropriate services*, *coordinated services*, *wraparound services*, and *cultural competence*.

Family Support Services — Help designed to keep the family together and to cope with mental health problems that affect them. These services may include consumer information workshops, in-home supports, family therapy, parent training, *crisis services*, and *respite care*.

Home-Based Services — Help provided in a family's home for either a defined time or for as long as necessary to deal with a mental health problem. Examples include parent training, counseling, and working with family members to identify, find, or provide other help they may need. The goal is to prevent the child from being placed out of the home. (Alternate term: in-home supports.)

Independent Living Services — Support for a young person in living on his or her own and in getting a job. These services can include *therapeutic group care* or supervised apartment living. Services teach youth how to handle financial, medical, housing, transportation, and other daily living needs, as well as how to get along with others.

Individualized Services — Designed to meet the unique needs of each child and family. Services are individualized when the *caregivers* pay attention to the child's and family's needs and strengths, ages, and stages of development. See *appropriate services* and *family-centered services*.

Inpatient Hospitalization — Mental health treatment in a hospital setting 24 hours a day. The purpose of inpatient hospitalization is: (1) short-term treatment in cases where a child is in crisis and possibly a danger to self or others, and (2) diagnosis and treatment when the patient cannot be evaluated or treated appropriately in an outpatient setting.

Managed Care — A way to supervise the delivery of health care services. Managed care may specify the *caregivers* that the insured family can see. It may also limit the number of visits and kinds of services that will be covered.

Mental Health — Mental health refers to how a person thinks, feels, and acts when faced with life's situations. It is how people look at themselves, their lives, and the other people in their lives; evaluate the challenges and the problems; and explore choices. This includes handling stress, relating to other people, and making decisions.

Mental Health Problems — Mental health problems are real. These problems affect one's thoughts, body, feelings, and behavior. They can be severe. They can seriously interfere with a person's life. They're not just a passing phase. They can cause a person to become disabled. Some of these disorders are known as depression, bipolar disorder (manic-depressive illness), attention deficit hyperactivity disorder, anxiety disorders, eating disorders, schizophrenia and conduct disorder.

Mental Disorders — Another term used for *mental health problems*.

Mental Illnesses — This term is usually used to refer to severe mental health problems in adults.

Plan of Care — A treatment plan designed for each child or family. The *caregiver(s)* develop(s) the plan with the family. The plan identifies the child's and family's strengths and needs. It establishes goals and details appropriate treatment and services to meet his or her special needs.

Residential Treatment Centers — Facilities that provide treatment 24 hours a day and can usually serve more than 12 young people at a time. Children with *serious emotional disturbances* receive constant supervision and care. Treatment may include individual, group, and family therapy; behavior therapy; special education; recreation therapy; and medical services. Residential treatment is usually more long-term than *inpatient hospitalization*. Centers are also known as *therapeutic group homes*.

Respite Care — A service that provides a break for parents who have a child with a *serious emotional disturbance*. Some parents may need this help every week. It can be provided in the home or in another location. Trained parents or counselors take care of the child for a brief period of time. This gives families relief from the strain of taking care of a child with a serious emotional disturbance.

Serious Emotional Disturbance — Diagnosable disorders in children and adolescents that severely disrupt daily functioning in the home, school, or community. Some of these disorders are depression, attention-deficit/hyperactivity, anxiety, conduct, and eating disorders. Serious emotional disturbances affect 1 in 20 young people.

Service — A type of support or clinical intervention designed to address the specific mental health needs of a child and his or her family. A service could be received once or repeated over a course of time as determined by the child, family, and service provider.

System of Care — A method of delivering mental health services that helps children and adolescents with mental health problems and their families get the full range of services in or near their homes and communities. These services must be tailored to each individual child's physical, emotional, social, and educational needs. In systems of care, local organizations work in teams to provide these services.

Therapeutic Foster Care — A home where a child with a *serious emotional disturbance* lives with trained foster parents with access to other support services. These foster parents receive special support from organizations that provide crisis intervention, psychiatric, psychological, and social work services. The intended length of this care is usually from 6 to 12 months.

Therapeutic Group Homes — Community-based, home-like settings that provide intensive treatment services to a small number of young people (usually 5 to 10 persons). These young people work on issues that require 24-hour-per-day supervision. The home should have many connections within an interagency *system of care*. Psychiatric services offered in this setting try to avoid hospital placement and to help the young person move toward a less restrictive living situation.

Transitional Services — Services that help children leave the system that provides help for children and move into adulthood and the adult service system. Help includes mental health care, *independent living services*, supported housing, vocational services, and a range of other support services.

Wraparound Services — A "full-service" approach to developing help that meets the mental health needs of individual children and their families. Children and families may need a range of community support services to fully benefit from traditional mental health services such as family therapy and special education. See *appropriate services, coordinated services, family-centered services,* and *system of care*.

Important Messages About Children's and Adolescents' Mental Health:

- Every child's mental health is important.
- Many children have mental health problems.
- These problems are real and painful and can be severe.
- Mental health problems can be recognized and treated.
- Caring families and communities working together can help.
- Information is available; call 1.800.789.2647.

For free information about children's and adolescents' mental health—including publications, references, and referrals to local and national resources and organizations—call 1.800.789.2647; TTY 301.443.9006.

3.14.96

BEST COPY AVAILABLE